(Please print)

Name_____Home Phone_____

Home Address_____Zip_____

Marital Status_____Birthdate_____Social Security #:_____

Occupation patient/parent_____Employer_____Phone_____

Parent or Spouse Name_____Employer_____Phone_____

Referred By_____Patient's Dentist_____How Long_____

Please list any family members we have seen_____

Person to Contact in an Emergency_____Phone_____

Dental Insurance Information

Subscriber's Name_____Relationship to Patient_____

Subscriber's Soc. Sec.#_____Subscriber's Birthdate_____

Insurance Co_____ Group#_____

Secondary Dental Insurance

Subscriber's Name_____Relationship to Patient_____

Subscriber's Soc. Sec.#_____Subscriber's Birthdate_____

Insurance Co_____Group #_____

- **If you have dental insurance:** Although we will file your claim as a service to you, the insurance contract is between you & the insurance company. We cannot guarantee anything your insurance company says regarding eligibility or benefits. Therefore, any difference of payment is entirely the responsibility of the patient or parent.

Financial Information

- Payment is expected at the time of service.
- Any balances including insurance related balances exceeding 60 days will receive an annual 18%, 1 1/2% per month interest charge.
- Accounts in default and turned over to a collection agency or for legal action will be charged a $50.00 processing fee in addition to any legal, collection, and court costs. NSF checks will result in a $20.00 charge.

Payment today will be: ❑ cash/check ❑ Mastercard/Visa/Discover/American Express

Financial Policy Acknowledged: signature_____date_____

** OVER **

MEDICAL HISTORY

- Physician's Name_____City_____State_____Phone_____

- List any medications, drugs, or pills you are currently taking: None___ _____

_____

- Are you aware of having an allergic (or adverse) reaction to any medication or substance?.....❑ Yes ❑ No

If yes, please list:_____

Indicate which of the following you have had, or have at present by marking the apropriate box:

Heart Attack		Special Diet		Tumors	
Heart Surgery		Diabetes		Liver Disease	
Pacemaker		Kidney Disease		Hepatitis A/B	
Angina		Ulcers		Venereal Disease	
Heart Murmur		Thyroid Problems		AIDS / HIV Positive	
High Blood Pressure		Glaucoma		Bruise Easily	
Mitral Valve Prolapse		Sinus Trouble		Hemophilia	
Other Heart Problem		Asthma		Neurological Disorder	
Rheumatic Fever		Latex Sensitivity		Epilepsy or Seizures	
Artificial Joint (hip, knee, ect)		Radiation Therapy		Psychiatric/Psychological Care	
Stroke		Chemotherapy		Nervous/Anxious	

- List previous surgeries in last 5 years: None____ _____

- Do you have or have you had any disease, condition, or surgery not listed?.....❑ Yes ❑ No

If yes, please list_____

- **Women:** Are you: **Pregnant?** ❑ Yes,_____months ❑ No **Nursing?** ❑ Yes ❑ No **Taking Birth Control Pills?** ❑ Yes ❑ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature_____Date_____

History Review *I* Update

WAYNE M. DUBIN, D. D. S., P.A.

PRACTICE LIMITED TO ENDODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowedgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Wayne M. Dubin, DDS, PA
Practice Limited to Endodontics

Consent for Endodontic Treatment

Endodontic therapy is the treatment of the inflamed or diseased pulp within the tooth. When completed, root canaled teeth generally function like your other teeth and have an excellent chance of remaining in your mouth for as long as your other teeth. The alternative to root canal treatment is generally extraction of the tooth.

The goal of root canal treatment is twofold: 1) to destroy and remove bacteria and diseased nerve tissue within the roots and 2) to seal the resulting empty canals to prevent future bacterial growth or leakage. Access to the canals is gained by drilling a small hole in the top or back of the tooth. Delicate instruments are then used to remove the pulp tissue and shape the canals to receive a filling. The procedure is completed by sealing the canals with an inert filling material. A temporary filling is then placed in the access opening. While this therapy is considered safe and effective, I want you to know about the risks and consequences of root canal treatment.

During Treatment

- An average of four to six xrays will be taken to determine the length for our instruments and filling materials. Endodontic treatment cannot be performed without these xrays. With our digital xray system, radiation is reduced by approximately 90%
- Despite our best efforts and the high success rate this procedure enjoys, there is a chance that the root canal treatment will not resolve your pain or infection. In such instances, other procedures such as retreatment, root tip surgery, or extraction may be necessary.
- Occasionally, canals are calcified or blocked preventing sealing of the root end. Similarly, instrument tips occasionally break off within the canal preventing sealing of the root end. In such cases, if a good seal cannot be established, root tip surgery or extraction of the tooth may be required.
- Occasionally, perforation of the root with instruments or root fracture may result in the need for surgical corrective treatment or extraction of the tooth.

If your treatment involves a tooth with existing crown or fixed bridge restorations, you must be aware of the risk of damage to that restoration resulting in additional cost to repair or replace that restoration by your restorative dentist.
Additional risks include infection, swelling of the gum or facial area, jaw joint pain (TMJ Problems), trismus (restricted jaw opening); and the risks associated with injection or the use of any medication (e.g. injury to blood vessels and nerves, allergic reaction, adverse drug reactions, and the medical risks associated with any dental procedure).

After Treatment

Since this is a specialty office, we only perform endodontic procedures. **Therefore, unless instructed otherwise, you must return to your regular dentist for placement of a permanent restoration** - usually a core build-up procedure followed by a crown. Failure to have a permanent restoration placed following root canal treatment may result in leakage of the temporary restoration and reinfection of the root canals (requiring retreatment of the root canal) or fracture of the tooth (often requiring extraction of the tooth).

CONCERNING TOOTH OR ROOT FRACTURES: We make every effort to detect fractures however, they are not always visible. If no fracture is detected during treatment, we cannot be responsible for any fractures that occur after treatment or are later detected.

Although this office uses state of the art equipment, materials, and techniques, and the majority of root canals are routine and successful, you need to be aware of the potential for any of the above risks. No guarantee of success has been or can be given in root canal treatment. Although the success rate is high (90-95%) there is also the risk that in the future the tooth could become reinfected and require retreatment or endodontic surgery or extraction (all at additional cost). The reasons for this are beyond our control and include resistant bacteria, extra canals, calcified canals, unusually shaped or located canals, or root fractures.

I invite your questions concerning the risks contained in this document. By signing below you acknowledge that you have read this document and understand the information presented.

(Please print)

Name _____ ***Signature*** _____ Date _____

Wayne M. Dubin, DDS, PA
6385 Presidential Court • Suite 103
Fort Myers, FL 33919
239-454-1661

Authorization and Consent
To Send Unnecrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Wayne M. Dubin, DDS to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and other involved in my treatment, payment for treatment, or Dr. Dubin's health care operations. The patient information that may be emailed may include either my xrays, health history, diagnosis, treatment, and payment records.

The primary purpose of this form is to allow us to email, without encryption, your exam and/or treatment reports and xrays to your dentist or whomever else you designate.

I understand that:

- I do not have to sign this form
- My treatment, payment, enrollment, and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form the information may be sent by other means, such as the US Mail, or I may be asked to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Wayne M. Dubin, DDS, PA *does not email such sensitive, personal information as Social Security number, credit card number,* mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails already sent before the written instructions were received to stop.

Patient name (please print)_____

Signature _____ Date _____

WAYNE M. DUBIN, D. D. S., P.A.

PRACTICE LIMITED TO ENDODONTICS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $ .20 for each page, $ 5.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Wayne M. Dubin, D.D.S.

Tel: 239/454-1661 Fax: 239/454-7232

6385 Presidential Ct. #103

Fort Myers, FL 33919