

DAVID C. KREUTZER, D.M.D., P.C.

NICOLE A. KARR, D.M.D.

PRACTICE LIMITED TO ENDODONTICS

11786 S.W. BARNES ROAD, SUITE 230  
PORTLAND, OR 97225  
503-644-4425

Today's Date \_\_\_\_\_

Name of Referring Dentist \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell / Mobile \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please check one: Minor  Single  Married  Separated  Divorced  Widowed

Would you like to be contacted via email? Yes  No  Email Address \_\_\_\_\_

If Minor, Name of Parent / Guardian \_\_\_\_\_

Patient's / Parent's or Guardian's Employer \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Fax Number \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Spouse's Work Phone \_\_\_\_\_ Spouse's Cell / Mobile \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

**RESPONSIBLE PARTY**

Name of Responsible Party for this Account \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Driver's License \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell / Mobile \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**METHOD OF PAYMENT**

Payment is due, in full, on the day of treatment. A detailed description of the payment methods is attached and must be signed.

**INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Driver's License \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union / Local # \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Fax Number \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_ Insurance Company Fax Number \_\_\_\_\_

How Much is the Deductible? \_\_\_\_\_ Max Annual Benefit \_\_\_\_\_ Amount Left \_\_\_\_\_

**SECONDARY INSURANCE**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Driver's License \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union / Local # \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Fax Number \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_ Insurance Company Fax Number \_\_\_\_\_

How Much is the Deductible? \_\_\_\_\_ Max Annual Benefit \_\_\_\_\_ Amount Left \_\_\_\_\_

To the best of my knowledge, the information I have provided on this form is accurate. I understand that providing incorrect information can be dangerous to my health. I authorize and request my insurance company to pay directly to the dentist the funds otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

\_\_\_\_\_  
DATE

## MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

Women: Are you Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

Aspirin     Penicillin     Codeine     Acrylic     Metal     Latex     Local Anesthetics

Other If yes, please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following?
- |   |  |  |  |
|---|--|--|--|
| <p>AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No</p> <p>Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No</p> <p>Anemia <input type="radio"/> Yes <input type="radio"/> No</p> <p>Angina <input type="radio"/> Yes <input type="radio"/> No</p> <p>Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No</p> <p>Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No</p> <p>Artificial Joint <input type="radio"/> Yes <input type="radio"/> No</p> <p>Asthma <input type="radio"/> Yes <input type="radio"/> No</p> <p>Blood Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No</p> <p>Breathing Problem <input type="radio"/> Yes <input type="radio"/> No</p> <p>Bruise Easily <input type="radio"/> Yes <input type="radio"/> No</p> <p>Cancer <input type="radio"/> Yes <input type="radio"/> No</p> <p>Chemotherapy <input type="radio"/> Yes <input type="radio"/> No</p> <p>Chest Pains <input type="radio"/> Yes <input type="radio"/> No</p> <p>Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No</p> <p>Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No</p> <p>Convulsions <input type="radio"/> Yes <input type="radio"/> No</p> | <p>Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No</p> <p>Diabetes <input type="radio"/> Yes <input type="radio"/> No</p> <p>Drug Addiction <input type="radio"/> Yes <input type="radio"/> No</p> <p>Easily Winded <input type="radio"/> Yes <input type="radio"/> No</p> <p>Emphysema <input type="radio"/> Yes <input type="radio"/> No</p> <p>Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No</p> <p>Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No</p> <p>Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No</p> <p>Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No</p> <p>Frequent Cough <input type="radio"/> Yes <input type="radio"/> No</p> <p>Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No</p> <p>Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No</p> <p>Genital Herpes <input type="radio"/> Yes <input type="radio"/> No</p> <p>Glaucoma <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hay Fever <input type="radio"/> Yes <input type="radio"/> No</p> <p>Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No</p> <p>Heart Murmur <input type="radio"/> Yes <input type="radio"/> No</p> <p>Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No</p> <p>Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No</p> | <p>Hemophilia <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hepatitis A <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No</p> <p>Herpes <input type="radio"/> Yes <input type="radio"/> No</p> <p>High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hives or Rash <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No</p> <p>Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No</p> <p>Kidney Problems <input type="radio"/> Yes <input type="radio"/> No</p> <p>Leukemia <input type="radio"/> Yes <input type="radio"/> No</p> <p>Liver Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No</p> <p>Lung Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No</p> <p>Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No</p> <p>Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No</p> <p>Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No</p> <p>Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No</p> | <p>Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No</p> <p>Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No</p> <p>Rheumatism <input type="radio"/> Yes <input type="radio"/> No</p> <p>Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No</p> <p>Shingles <input type="radio"/> Yes <input type="radio"/> No</p> <p>Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No</p> <p>Spina Bifida <input type="radio"/> Yes <input type="radio"/> No</p> <p>Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Stroke <input type="radio"/> Yes <input type="radio"/> No</p> <p>Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No</p> <p>Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Tonsillitis <input type="radio"/> Yes <input type="radio"/> No</p> <p>Tuberculosis <input type="radio"/> Yes <input type="radio"/> No</p> <p>Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No</p> <p>Ulcers <input type="radio"/> Yes <input type="radio"/> No</p> <p>Venereal Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No</p> |
|---|--|--|--|

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

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## **METHOD OF PAYMENT AGREEMENT**

**Please take note that you are solely responsible for your account, not your insurance carrier nor any other third party.**

As a courtesy to our patients, we offer several methods of payment.

For your convenience, we:

- bill your dental insurance on your behalf
- accept cash, personal check, Visa, MasterCard, American Express and Discover
- offer interest-free payment plans for those who qualify/obtain credit approval through CareCredit

**It is the office policy that payment is due, in full, at the time of treatment.**

**When billing dental insurance,** we request that a deposit of 25% of the total charges be paid by you on the day of treatment. The 25% deposit may be paid with cash, personal check, Visa, MasterCard, American Express or Discover. We will process your insurance information, collect the funds directly from the insurance company and apply to your account. Should there be a credit to your account, we will promptly refund that amount. Should your insurance provider not cover the full amount and there is a balance due, we will send you a statement that is due without delay. If we have not received payment from your insurance company within 60 days of your treatment, you will be billed the balance and your payment is due without delay. If, after 60 days you have settled your account with us and we subsequently receive payment from your insurance company, we will promptly remit to you the insurance payment.

Typically we receive insurance payments within 60 days of submitting a claim, however it is your responsibility to ensure that your account has been settled by this time. We encourage you to keep informed of the status of your insurance claim with your insurance provider. It is our experience that the more up to date you are with the status of your insurance, the faster the claims will be processed.

**If you do not have dental insurance,** payment is due, in full, at the time of treatment. Again, for your convenience, we accept cash, personal check, Visa, MasterCard, Discover or American Express.

Interest will be charged at 1.5% per month for all accounts over 60 days old. **A \$50.00 processing fee will be applied to all accounts over 60 days old that must be referred to collections.**

**Returned Checks:** A \$50 service charge will be applied to all accounts with checks returned for non-sufficient funds.

**Missed or Cancelled appointments:** We reserve the right to request a non-refundable deposit equal to 25% of the patient's proposed treatment costs prior to re-scheduling any previous missed appointments and/or cancellations with less than 24 hours notice. This deposit is taken to reserve the re-scheduled appointment. If this re-scheduled appointment is cancelled with less than 24 hours notice, or if the patient fails to show for the appointment, we will retain the 25% deposit fee. If the appointment is kept as scheduled, the 25% deposit will be applied to the payment balance of the proposed treatment.

**Failure to complete treatment:** If treatment is initiated but not completed due to patient failure to return for completion of treatment, 50% of the quoted fees will be charged.

**Please select your method of payment:**

**Please bill my dental insurance. I will pay my 25% deposit with:**     Cash     Personal Check     Credit Card

**I do not have dental insurance. I will pay with:**                       Cash     Personal Check     Credit Card     CareCredit

I have read and fully understand the payment policy of this office. I have had all my questions answered to my satisfaction regarding the payment options available to me. I agree to the above information and terms. I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment of benefits.

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SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT

DATE

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## **CONSENT & INFORMATION**

It is the belief of this office that you should be informed about the treatment (therapy) and that you should give your consent before starting the treatment. The purpose of this form is to outline the risks that may occur in endodontic (root canal) treatment and other treatment choices. Risks of treatment are of two kinds: those risks involved in general dental procedures, and those risks specific to endodontic treatment.

**Risks of dental procedures in general:** Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections in the lip, tongue, chin, gums, cheeks and teeth, reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, delayed healing, sinus complications, and further surgery. Medications (prescribed) may cause drowsiness and lack of awareness and coordination, thus it is advisable not to operate any vehicle or hazardous device until recovered from their effects.

**Risks more specific to endodontic therapy:** These risks include instruments broken within the root canals, perforations (extra openings) of the crown or root of the tooth, damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include blocked canals due to fillings, prior treatment, natural calcification, broken instruments, curved roots, periodontal disease, splits or fractures of teeth.

**The other treatment choices include:** no treatment, waiting for more definite development of symptoms, having the tooth removed. Risks involved in these choices may include pain, swelling, infection, loss of tooth, and infection to other areas. Treatment will be done in a manner to minimize or avoid risks.

Root canal treatment is an attempt to retain a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

**I, being the patient (parent or guardian) acknowledge that I have read and understand the aforementioned risks and alternative treatment choices and give written consent to the performing of a thorough endodontic exam.**

SIGNATURE OF PATIENT, PARENT OR GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

**I have discussed and understand all treatment options available to me (including no treatment) with the doctor. I give my consent for those procedures decided upon to be necessary or advisable in the opinion of the doctor and understand the risks involved.**

Patient Initials \_\_\_\_\_

- |   |               |
|---|---------------|
| <input type="checkbox"/> Root Canal Treatment             | Tooth # _____ |
| <input type="checkbox"/> Root Canal Retreatment           | Tooth # _____ |
| <input type="checkbox"/> Apicoectomy / Endodontic Surgery | Tooth # _____ |
| <input type="checkbox"/> Other _____                      | Tooth # _____ |