Montana Mobile Endodontics
Scott D Jarrett DDS
Practice Limited to Endodontics
Phone: (406)499-2223 Email: info@mobileendo.com
www.mobileendo.com

PATIENT REGISTRATION

Welcome to our practice. Thank you for providing the following confidential information so that we can adequately provide care for your needs.

PATIENT INFORMATION (Please Print)

Title (Please Circle One) Dr. Mr. Mrs. Ms. Miss

Name _____
(Last) (First) (M/I)

Home Address _____
(Street) (City) (State) (Zip)

Home Phone # _____ Cell Phone # _____

Email _____

Social Security Number_____ Birth Date _____

Employer (Parent's Employer If Minor) _____

Parent's Name _____ Spouse's Name _____
(If Patient Is a Minor)

Spouse's Employer _____

Whom May We Contact In Case Of Emergency? _____

Relationship _____ Phone # _____

Whom May We Thank For Referring You to Us? _____

Dental Insurance Information: Insurance Company _____

Insurance Address _____Insurance Phone # _____

Insured's Name _____ Insured's Birth Date _____

Group # _____ ID # _____

Who is Financially Responsible For This Bill? _____
(Please Read and Sign Financial Policy and Insurance Form)

I Will Be Paying Today By (Please Circle One) Cash Check Credit Card CareCredit

PATIENT HISTORY

Your medical history is important to us. Please answer all questions regarding your current and past health status as completely as possible. You can be assured that all information provided will be held in strict confidence according to our posted privacy policies.

For what reason have you been referred to our office?_____

MEDICAL HISTORY

Primary Care Physician's Name:_____Phone Number_____

Please circle or place an X next to "Yes" or "No" for each of the following:

Yes	No	Heart Attack/Angina	Yes	No	Tuberculosis	Yes	No	Drug or Alcohol Dependency
Yes	No	Stroke	Yes	No	Lung Disease	Yes	No	Problem with Immune System
Yes	No	Diabetes	Yes	No	Liver Disease/Hepatitis	Yes	No	Herpes/Cold Sores
Yes	No	High Blood Pressure	Yes	No	Kidney Disease	Yes	No	Tobacco use
Yes	No	Cancer	Yes	No	Gastrointestinal Disease	Yes	No	Chest Pain
Yes	No	Heart Defect	Yes	No	Anemia	Yes	No	Shortness of Breath
Yes	No	Rheumatic Heart Disease	Yes	No	Epilepsy/Seizures	Yes	No	Swollen Ankles
Yes	No	Mitral Valve Prolapse	Yes	No	Glaucoma	Yes	No	Excessive Thirst or Urination
Yes	No	Heart Valve Replacement	Yes	No	Radiation/Chemotherapy	Yes	No	Dizziness
Yes	No	Pacemaker	Yes	No	Prosthetic Joint	Yes	No	Fainting Tendency
Yes	No	Asthma	Yes	No	Bleeding Disorder	Yes	No	Headache
Yes	No	Chronic cough>3weeks	Yes	No	Bloody sputum	Yes	No	Unexplained weight loss
Yes	No	NightSweats	Yes	No	Recent travel out of the U.S. or live in concentrated housing with or without another tuberculosis patient			

Other pertinent medical history: _____

DENTAL HISTORY

Please circle or place an X next to "Yes" or "No" for each of the following:

Yes	No	Are you Currently in Pain	Yes	No	Neck or Facial Swelling	Yes	No	Severe Dental Anxiety
Yes	No	Pain withBiting	Yes	No	White or Yellow Drainage	Yes	No	Numbness or Tingling
Yes	No	Pain to Hot Food or Drink	Yes	No	Swollen Lymph Nodes	Yes	No	Pain in Jaws
Yes	No	Pain to Cold Food or Drink	Yes	No	Fever	Yes	No	Difficulty Opening Mouth
Yes	No	Gum Tenderness	Yes	No	Sinus Pain	Yes	No	Previous Root Canal

Other pertinent dental history: _____

MEDICATIONS AND ALLERGIES

List **Current Medications** (prescribed, over the counter, **and** contraceptive medications):_____

_____

List All **Allergies** (such as antibiotics, local anesthetic, pain medications, ibuprofen, latex, or foods):_____

_____

Have you received or are you currently receiving medication known as bisphosphonates (for example; zoledronic acid [Zometa], pamidronate [Aredia], alendronate [Fosamax], risedronate [Actonel], or ibandronate [Boniva]): Y / N If yes, how long?_____

Do you need antibiotics prior to dental appointments?_____ If yes, why?_____

Have you taken steroids in the past year?_____ If yes, when and at what dosage?_____

Can you take Ibuprofen?_____Yes_____No If no, why_____

FEMALES ONLY

Are you pregnant? **Y / N** If yes, how many months?_____ Could you be pregnant? **Y / N** Are you breast feeding? **Y / N**

I, _____ attest that the above medical history is true to the best of my knowledge.
(Print or Type Name of Patient or Legal Designate)

_____ _____

Signature of Patient or Legal Designate **Date**

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CONSENT FOR ENDODONTIC TREATMENT

I _____ understand that root canal treatment is a procedure to
(Print or Type Name of Patient or Legal Designate)

retain a tooth which may otherwise require extraction. I have been informed of possible alternative methods of treatment, including no treatment, and the possible benefits or adverse results from these alternative treatments.

I understand that root canal treatment can have a very high degree of clinical success (85-95% of routine cases are successful); however, as with any branch of medicine or dentistry, no guarantee of successful treatment can be given or implied. Occasionally, a tooth which has had root canal treatment may require revision (re-treatment), a surgical procedure, or even extraction.

Treatment will be performed in accordance with accepted methods of clinical practice. This will require the administration of local anesthetic agents and placement of a rubber dam. In addition, a number of radiographs (X-rays) will be necessary to accomplish the root canal procedure. The number of radiographs will vary with the complexity of the case.

I have been informed and understand that there are certain inherent and potential risks in any treatment procedure. These include swelling; bruising; bleeding; discomfort; infection; numbness or tingling of the lips, tongue and/or jaw; and difficulty in opening or closing my mouth. Most of these complications are temporary in nature, but it is possible to have permanent changes in the form of pain, numbness, or tingling in lips, tongue, and/or jaw. Fractures of existing restorations (especially porcelain crowns), the tooth, and/or instruments used to perform the treatment may occur. Additionally, variations in canal shape and size may complicate treatment and result in a perforation (hole) in the root or a root canal filling that is less than desirable. Additional unknown or unspecified problems may occur, the explanation for and the responsibility of which cannot be given or assumed.

I understand that to accomplish the root canal procedure it is necessary to alter the existing tooth structure and/or restoration. These alterations require the placement of a new restoration or crown following endodontic therapy to protect the tooth from bacterial leakage and fracture leading to subsequent re-infection and/or the loss of the tooth. The fee for endodontic treatment does not include these restorative procedures. In addition, I understand that it is my responsibility to have a permanent restoration placed as soon as possible (within 30 days) following the root canal procedure.

Female Patients Only: The administration of antibiotics may decrease the efficacy of oral contraceptive medications. For this reason, additional barrier contraceptive methods should be employed for one month following treatment.

I understand that I am free to withdraw my consent and discontinue treatment at any time; however, complications such as bone destruction, infection and swelling, tooth loss, and/or pain, etc. may predictably occur if the root canal treatment is not completed.

Any and all questions pertaining to diagnosis and treatment have been answered to my satisfaction by Dr. Jarrett prior to signing this form.

_____ _____ _____

Signature of Patient or Legal Designate **Date** Tooth #

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FINANCIAL POLICY AND DENTAL INSURANCE

Montana Mobile Endodontics is committed to providing you the best possible care. If you have dental insurance, we will do our best to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility on the date that services are rendered in the form of either cash, check, or credit card payment. If you would like, we will submit an insurance claim on your behalf to help you obtain direct reimbursement. If the insurance company ends up writing the check to Montana Mobile Endodontics, we will promptly issue you a refund in the amount that was sent to us. We strongly recommend monitoring the status of your claim periodically and calling your insurance company if your claim is not paid in a timely fashion (usually 30 days). The reason that this is effective is because the insurance company's relationship is with you, not us. As such, they are more responsive to inquiries and demands from the patients they insure (i.e. their customers) as opposed to the health care providers attempting to obtain reimbursement on your behalf.

Regardless of your insurance company's response to any claim submitted on your behalf by Montana Mobile Endodontics, your balance will be immediately due 90 days from the date of treatment unless other arrangements have been agreed upon in writing.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I _____ have reviewed the financial policies of Montana Mobile Endodontics,
(Print Name of Patient or Legal Designate)

and I agree to be personally responsible for all charges for all dental services rendered to me by Montana Mobile Endodontics. I understand that I am responsible for these charges regardless of whether or not my insurance company approves or denies my claim and that all monies owed for treatment rendered by Montana Mobile Endodontics will become overdue 90 days from the date of said treatment. To the extent permitted under applicable law, I authorize release of any information relating to this claim. I further agree that if my account is not paid as agreed above and Montana Mobile Endodontics should retain an attorney or collection agency for collection, I agree to pay all costs of collections including reasonable interest, reasonable attorney's fees (whether or not a lawsuit is filed) and reasonable collection agency fees in the amount of 50% of the balance due.

_____ _____
Signature of Patient or Legal Designate **Date**

PRIVACY POLICIES

I _____ have been offered a copy of Montana Mobile Endodontic's Privacy Policy.
(Print Name of Patient or Legal Designate)

_____ _____
Signature of Patient or Legal Designate **Date**