PATIENT INFORMATION

NAME: _____
Last First Middle Initial Preferred Name

SEX: □ Male □ Female STATUS: □ Single □ Married □ Child

BIRTHDATE: _____-- _____ -- _____ **SOCIAL SECURITY #**: _____--_____--_____

ADDRESS:_____
Street City State ZIP

PHONE #: ( ) _____--_____ ( ) _____--_____ _____ ( )_____--_____
Home Work Ext. Cell

YOUR EMPLOYER (NAME & PHONE NUMBER): _____

HAS SOMEONE IN YOUR HOUSEHOLD BEEN A PATIENT HERE PREVIOUSLY? □ Yes □ No
IF YES, NAME AND BIRTHDATE OF FAMILY MEMBER: _____

****GENERAL DENTIST IS****: Referred by (if other specialist):

OFFICE PAYMENT POLICY-- PLEASE READ AND SIGN

PATIENTS WITH DENTAL INSURANCE : **The fee for our doctors' services is your responsibility.** Full payment is expected the day of your appointment for the exam of $50 & CBCT of $95 (if needed) regardless of insurance. As a convenience to you, we will help you file your insurance claim. If you are here for endodontic treatment, we will submit your insurance claim, but **we do expect your estimated portion of your treatment cost today; please ask for our fees.** Knowledge of your insurance coverage is your responsibility and time does not always allow us to obtain this information prior to you being seated and electing treatment.

PREFERRED METHOD OF PAYMENT:

□ CASH □ CHECK (Alamance Co. Residents ONLY) □ CREDIT / DEBIT / HSA

□ CARECREDIT-- **must be approved in advance of treatment**. We offer 6 months interest free.

PATIENTS WITH NO DENTAL INSURANCE: **Payment in full is expected today; please ask for our fees.** We do not accept extended personal payments; however, we utilize an outside financing agency (CareCredit) to assist you with payment arrangements. Please see our front office staff for more information.

PREFERRED METHOD OF PAYMENT:

□ CASH □ CHECK (Alamance Co. Residents ONLY) □ CREDIT / DEBIT / HSA

□ CARECREDIT-- **must be approved in advance of treatment.** We offer 6 months interest free.

ALL PATIENTS: An 18% annual (1.5% monthly) finance charge will be applied to balances beyond 90 days.

I have read the above information and certify that I am the patient/guardian of the patient and am authorized to furnish the information requested. **I understand that I, not my insurance company, am responsible for payment of the services rendered by Robert E. Jepko, DDS, PA.** I further agree to be solely responsible for any collection costs associated with my account.

SIGNATURE: _____ **DATE:**_____

ROBERT E. JEPKO, DDS PA 1155 Huffman Mill Road, Burlington, NC 27215 (336) 586-9696

FILING YOUR INSURANCE CLAIM

Our office is pleased to help file your claim forms and assist you in getting your claim paid. Our office does NOT guarantee payment by your insurance company. We will make every attempt, at the beginning of your dental care, to receive verification of your policy and an *estimate* of what it covers. However, knowledge of your insurance coverage is your responsibility and time does not always allow us to obtain this information prior to you being seating and electing treatment.

It must be fully understood that our estimate is NOT a guarantee of payment. The contract is between you and your insurance company and that you are fully responsible for any amount not paid by your insurance.

Our office policy regarding insurance assignment:

1. The courtesy of accepting your insurance assignment may be withdrawn if circumstances warrant.

2. If you discontinue care without the Doctor's authorization or do not return to have an emergency procedure completed, the balance of your account is due and payable in full immediately, even if your insurance has been filed. (If the insurance does pay, it will be refunded if you have a zero balance.)

3. Your insurance should pay within 30 days. If your insurance has not paid within 45 days, you must pay the balance due and be reimbursed by your insurance company when and if it pays.

4. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.

5. In the event that your insurance company pays you directly, your obligation is to send us a check for your dental services immediately upon receipt of the insurance check.

6. All special arrangements regarding finances must be signed by you as the patient/guardian and our Office Manager. This office accepts cash, check (residents of Alamance County), MasterCard, Visa, and Discover as payment.

***If you understand and agree with all of the policies,
please sign your name below and we will submit your insurance claim for you.***

An extended payment plan with 6 months free interest is available through CareCredit only.

PRIMARY INSURANCE INFORMATION:	**SECONDARY INSURANCE INFORMATION:**
NAME OF SUBSCRIBER *PERSON* or POLICY HOLDER:	NAME OF SUBSCRIBER *PERSON* or POLICY HOLDER:
_____	_____
Relationship: Self Spouse Parent	Relationship: Self Spouse Parent
SUBSCRIBER BIRTHDATE:_____	SUBSCRIBER BIRTHDATE:_____
SUBSCRIBER ID/SS #: _____-_____-_____	SUBSCRIBER ID/SS #: _____-_____-_____
SUBSCRIBER'S EMPLOYER:	SUBSCRIBER'S EMPLOYER:
_____	_____
Name of DENTAL Insurance Company:	Name of DENTAL Insurance Company:
_____	_____
Group # : _____	Group # : _____

SIGNATURE of Patient, Parent, or Guardian: _____

DATE: _____

MEDICAL HISTORY

1. Have you been an inpatient in the hospital **or** been under the care of a medical doctor during the past two years? ..... ❑ YES ❑ NO
   If yes, for what reason? _____

2. Are you **allergic** to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, latex, epinephrine, or any drugs, medications or any household cleaning products? ❑ YES ❑ NO
   If yes, please list: _____

3. Have you ever been diagnosed with pseudomembranous colitis **or** c-diffcile colitis? Have you noticed if certain medications give you diarrhea? (name): _____❑ YES ❑ NO

4. Have you ever taken **or** are you currently taking any biphosphonate medications, such as: Zometa, Aredia, Fosamax, Actonel, Boniva, Skelid, Bonefos/Ostac, or Didronel? (name): _____❑ YES ❑ NO

5. Are you on any blood thinning medications? (name): _____❑ YES ❑ NO

6. Check any of the following which you have had or have at present:

- ❑ Heart Failure
- ❑ Heart Murmur
- ❑ Mitral Valve Prolapse
- ❑ Artificial Heart Valve
- ❑ Artificial Joint *when?*
- ❑ Heart Disease or Attack
- ❑ Angina Pectoris (chest pain)
- ❑ High Blood Pressure (hypertension)
- ❑ Congenital Heart Lesions
- ❑ Heart Surgery
- ❑ Heart Pacemaker
- ❑ Scarlet Fever
- ❑ Rheumatic Fever
- ❑ Anemia
- ❑ Stroke
- ❑ GERD (reflux)
- ❑ Ulcers
- ❑ Cancer or Tumor
- ❑ Shortness of Breath
- ❑ Cough, Emphysema
- ❑ Tuberculosis (TB)
- ❑ Asthma
- ❑ Hay Fever
- ❑ Sinus Trouble
- ❑ Allergies or Hives
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ X-Ray or Cobalt Treatment
- ❑ Chemotherapy (Cancer, Leukemia)
- ❑ Arthritis
- ❑ Rheumatism
- ❑ Cortisone Medication
- ❑ Glaucoma
- ❑ Pain in Jaw Joints
- ❑ HIV Positive (AIDS)
- ❑ Hepatitis A (infectious)
- ❑ Hepatitis B (serum)
- ❑ Hepatitis C
- ❑ Liver Disease
- ❑ Kidney Trouble
- ❑ Blood Transfusion *when?*
- ❑ Drug Addiction
- ❑ Hemophilia
- ❑ Cold Sores or Fever Blisters
- ❑ Epilepsy or Seizures
- ❑ Fainting or Dizzy Spells
- ❑ Nervousness (Excessive)
- ❑ Psychiatric Treatment
- ❑ Sickle Cell Disease
- ❑ Bruise Easily
- ❑ Bleeding Disorder
- ❑ **NONE OF THE ABOVE**

7. Do you have any disease, condition or problem not listed?..... ❑ YES ❑ NO

8. Please list all medications you are currently taking. NONE LIST ATTACHED

_____

_____

_____

9. **Preferred Pharmacy Name & Location:**_____

10. Women: Are you Pregnant? ❑ YES ❑ NO *If yes*, what month are you due?_____
    Are you taking birth control pills? ❑ YES ❑ NO Certain antibiotics may reduce the effectiveness of this medication.

♦ **UPON COMPLETION OF ROOT CANAL TREATMENT, I UNDERSTAND THAT I AM TO RETURN TO MY REGULAR DENTIST FOR THE PERMANENT RESTORATION (FILLING AND/OR CROWN).**

Signature:_____Date:_____ Updated: _____ Initialed:_____

**** CONTACT PERSON, IN CASE OF AN EMERGENCY: _____**

Robert E. Jepko D.D.S., PA

1155 Huffman Mill Road, Burlington, NC 27215 (336)538-9696

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME:_____ DATE OF BIRTH: _____

Robert E. Jepko, DDS, PA reserves the right to release your healthcare information based upon the decision by Dr. Jepko for medical emergency situations and in general for continuity of care. We will release your information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it. For continuity and quality of care, we may also receive information regarding your prescriptions from your pharmacy.

You have been offered a copy of our "Notice of Privacy Practices" that contains a complete description of the uses and disclosures covered under this consent. You have been given time to review the "Notice of Privacy Practices" and we have encouraged you to read it and ask any questions that you may have prior to signing this consent.

Our office reserves the right to change the privacy practices as stated in the "Notice of Privacy Practices". You will be given a copy of the revised notice with your first office visit following any change. The most current notice is prominently posted, and copies are available in our reception area.

You have the right to request that we restrict how your health information is used or disclosed. We are not required to agree to your requested restriction, but if we do agree to the restriction, we will honor the restriction.

You have the right to revoke this consent except to the extent that we have already taken action covered under the consent. If you choose to revoke this consent, you must do so in writing. Please understand that we will decline to treat you or continue to treat you if you revoke this consent.

AUTHORIZATION FOR RELEASE OF INFORMATION

DISCLOSURE OF INFORMATION/ FAMILY & FRIENDS:

With whom may we discuss the patient's health information? (please print)

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

May we also disclose financial information? (circle one) Yes No

We reserve the right to contact you (call, email or text) regarding your appointment(s) and/or leave information on your answering machine / voicemail.

This consent must be signed by the patient and dated:

_____ _____

Signature of Patient or Responsible Party Relationship if Not Patient

_____ _____

Printed Name **Date**

ENDODONTIC INFORMATION AND CONSENT FORM

Please be reassured that we use accepted infection control procedures and universal precautions for the protection of our patients and staff.

Endodontic Root Canal Therapy, Endodontic Surgery, Anesthetics, and Medications

While serious complications associated with root canal therapy are very rare, we would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy or, when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment, and other treatment choices.

Risks: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (Pain Killers), anesthetics, and injections. These complications include (but not limited to) swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth—which is transient but, on infrequent occasions, may be permanent; reaction to injections; changes in occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck, and head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations; and treatment failure.

Risks More Specific to Endodontic Therapy: Endodontic treatment, like treatment to any part of the body, has some risks. The risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns, porcelain veneer or surrounding tissue; 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 or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), and splits or fractures of the teeth.

Medications: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedative, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

Women Taking Birth Control: Certain antibiotics may reduce the effectiveness of birth control medication. Please take necessary precautions.

Other Treatment Choices: These include no treatment, waiting for more definite development of symptoms, or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

CONSENT:

I, the undersigned, being the patient (parent or guardian of minor patient), consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. *I also understand that, upon completion of root canal therapy in this office, I should return to my general family dentist for a permanent restoration (such as a crown, cap, jacket, onlay, or silver or white filling) of the tooth involved.* I understand that with the cooperation of the patient, root canal treatment is an attempt to save a tooth which may otherwise require extraction. Endodontic treatment can be carried out successfully in most, but not all, cases. It cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery or extraction.

Signature of patient, parent or guardian:_____ Date:_____