Advanced Endodontics
JEFF BERLIN, DDS, MS BEVERLY HILLS

8920 WILSHIRE BLVD, SUITE #403
BEVERLY HILLS, CA 90211

O 310.855.0444 F 310.855.1001

WELCOME TO OUR OFFICE

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient's Birth Date: _____ Age: _____ Sex: Male ☐ Female ☐

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Email: _____

Driver License # _____ Social Security # _____

Responsible Person or Parent if Patient is a Minor: _____

Emergency Contact: _____ Phone: _____

REFERRAL INFORMATION

Dentist: _____ Physician: _____

Other: _____

INSURANCE INFORMATION

Name of Insured: _____

Relationship to Insured: _____ Insured Social Security # _____

Insured Employer's Name: _____ Insured Birthdate: _____

Insurance Company: _____ Group ID# _____

Any Secondary Insurance Coverage? _____

Payment is due in full at time of service. Thank you.

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MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

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 list your medications below in the space provided.

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? ☐ Nursing?

☐ Taking oral contraceptives?

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?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ☐ Yes ☐ No If yes, please explain: _____

PLEASE LIST YOUR CURRENT MEDICATIONS: _____

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.

Date: _____ Patient/Parent Signature: _____

Advanced Endodontics

Office Policies and Financial Agreement:

Please read carefully and feel free to ask any questions you may have *before signing in agreement below*.

Your appointment will begin with a consultation. This includes an exam and any necessary x-rays. For your consultation today you will be responsible for **$195-$395.** We will make every effort to acquire and use any x-rays you have had recently, but in order to ensure the diagnostic quality of the images and in the interest of keeping our appointments running on time, it is often necessary to take our own x-ray. X-rays are critically necessary to your consultation and diagnosis. Any x-rays will be completed at no additional cost as part of your consultation. We want to make sure you understand your treatment, your options and your financial responsibility before you agree to proceed with treatment. Following the exam, all findings and treatment recommendations will be clearly presented and the costs to proceed with these recommendations will be discussed with you before treatment begins. The cost of a root canal can range from **$2195 - $3495** depending on the location of the tooth and its severity. ***I _____ understand that once I have agreed to proceed with treatment I am responsible for all fees as presented to me for this service.***

In an effort to do our part for the environment we have eliminated paper statements. As such, payment is expected in full at the time services are rendered. We gladly accept Cash, Visa, MasterCard, Discover and American Express, as well as flex spending. We have also partnered with Care Credit to offer 6 month *interest free* or 24 month *fixed interest* financing options (upon approval).

Patients with dental insurance please read the following information about your benefits and their effect on your financial responsibility.

We are happy to accept all PPO dental insurances and we are in-network with some. We do not accept HMO or medical insurances. Your insurance is a contract between you and your insurance company. As a courtesy the financial representatives of Advanced Endodontics will help you understand how your benefits may be applied toward your treatment and will submit claims on your behalf to your insurance company. As part of this courtesy, Advanced Endodontics will contact your insurance company and try to *estimate* what the insurance will pay and the patient portion of payment expected for your services. ***I _____ understand that my presented co-pay is only an estimate and not a guarantee of any payment or reimbursement from my insurance company. I understand that I am fully responsible for any payments due to Advanced Endodontics that are denied by my insurance.*** As such, if there is still a balance due after your insurance has processed your claims you will be notified of your balance and it *will be charged to your card on upon* receipt of final insurance payment or denial. Likewise if the insurance pays more than expected and you are due a refund, the credit *will be refunded to you upon* receipt of final insurance payment.

I have read the above and understand my full financial responsibility to Dr. Berlin for any and all services rendered to me from this date forward regardless of my insurance coverage.

Print Full Name: _____ Patient Signature: _____ Date: _____

Preferred Method of Payment on File: ☐ CASH ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ CARECREDIT

Name of Cardholder: Last 4 of card number: Expiration: CVC Billing Zip

_____

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INFORMED CONSENT FOR TREATMENT

ROOT CANAL AND LOCAL ANESTHETIC

I, the undersigned, being the patient, (parent, or guardian of the minor patient) consent to performing the dental procedure decided upon to be necessary or advisable, in the opinion of the doctor, on the tooth indicated for treatment. I understand that root canal treatment is an attempt to retain the tooth which may otherwise require an extraction. Although root canal therapy usually has a high degree of success, it cannot be guaranteed. Occasionally, a tooth that has had a root canal therapy may require re treatment, surgery or even extraction. Access through a crown or bridge may result in damage to the restoration requiring repair or replacement by your general dentist. Treatment may be discontinued due to the calcified canals, accidently broken (separated) instruments or fracture of the crown or root. Separation of root canal instruments during treatment may, in the judgement of the doctor, be left in the canal or require surgical treatment. I understand that doing a root canal treatment through crowns may hide existing decay or cracks, that are not visible to the doctor, and therefore I cannot hold the doctor responsible for missing them. I understand upon completion of root canal therapy in this office, I am responsible to contact my general dentist within a timely manner, not to exceed one month, for a permanent restoration such as a crown, or filling to protect the tooth from fracture or reinfection.

Patient/Parent Signature: _____ Date: _____

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Patient HIPAA Consent Form

You have certain rights to privacy regarding your protected health information under the Health Insurance Portability Act of 1996 (HIPAA). By signing this consent, you authorize this office (Jeff Berlin, DDS, MS and Associates) to use and disclose your protected health information to carry out the following:

- Treatment and reporting treatment notes to your Doctors (including direct or indirect treatment by other health and dental care providers involved in your treatment)
- Obtaining payment from third party payers (e.g. your insurance company)
- The day-to-day healthcare operations of our practice (e.g. contact with you and authorized members of your care)

Print Patient Name_____

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations. I have also been informed that I may request and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this notice is not affected.

Signature_____ Date signed _____