David C. Kreutzer, D.M.D., P.C.
Practice Limited to Endodontics

11786 S.W. Barnes Road, Suite 230
Portland, Oregon 97225
503-644-4425

Today's Date _____

PATIENT INFORMATION

Name of Referring Dentist _____

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.

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured_____ Relationship to Patient _____

Social Security #/Member ID # _____ Date of Birth _____

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 DENTAL INSURANCE INFORMATION

Name of Insured_____ Relationship to Patient _____

Social Security #/Member ID # _____ Date of Birth _____

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

PAIN HISTORY QUESTIONNAIRE **Name:** _____ **Date:** _____
(please circle your responses)

1. In your own words, can you explain the reason for your visit today?

   _____

   _____

2. Have you experienced pain in this tooth any time in the past? **Yes / No**
   If yes, when did you first notice the pain symptoms? _____

3. Are you in pain now? **Yes / No**

4. If you are in pain now, how long have you been in pain?
   1 day / 2 days / 3 days / 4 days / 5 days / 6 days / 1 week /
   2 weeks / 3 weeks / > 3 weeks / Other: _____

5. Did this pain either keep you awake or awaken you last night? **No / No, but it has before /**
   Yes / Yes, and I have been up all night in pain

6. Can you locate the tooth that is causing the pain?
   Yes / No / Not sure / There may be more than one tooth

7. Does the pain radiate to other parts? **Yes / No / Not now but has in the past**
   Radiates to: **Left side Upper jaw / Lower jaw / Sinus / Ear / Temple / Neck / Shoulder**
   Right side Upper jaw / Lower jaw / Sinus / Ear / Temple / Neck / Shoulder

8. Is the pain spontaneous or does it always require some stimulus to become painful?
   I have spontaneous pain / It always takes some stimulus to make it hurt /
   I don't have spontaneous pain now, but have in the past with this tooth

9. Do you feel swollen now? **Yes / No** Has there been a history of prior swelling? **Yes / No**

10. How would you rate the severity of your pain today (as a number and description, 0=no pain,
    1=very slight pain ...10=unbearable pain)? **0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10**

11. Please circle the frequency and nature of pain that most closely describes your discomfort:
    Constant / Intermittent / Momentary / Only when chewing or biting / Sharp / Dull /
    Radiating / Throbbing / Migrating / Aching / Gnawing / Enlarging to other areas /
    Variable / Shooting / Tingling / Itching / Burning / Zinging

(continued back side of page)

12. Do you have lingering pain (more than a few seconds)? **Yes / No / No but I have in the past**

13. Is the tooth sensitive to temperature? **No / No, but temperature sensitive in the past / More sensitive to cold than hot / More to hot than cold / Equally to hot and cold / Not sure**

14. What relieves the pain? **Nothing / Cold / Hot / Massage / Vicodin / Non-biting / Aspirin / NSAIDS / Codeine / Advil / Aleve / Antibiotics / Percocet / Tylenol / Other:** _____

15. If you don't touch the tooth or bite, does it still hurt? **Yes / No / Sometimes / Only if I bite in a certain way / Not now, but it has in the past**

16. What increases the pain? **Touching / Biting / Cold / Hot / Eating / Cold air / Lying down / Pressing on gum / Flossing / Nothing / Sweets / Other:** _____

17. What is the course of the pain? **Increasing / Decreasing / Constant / Variable / None now**

18. Has there been any recent dental work done in this area? **Yes / No / Not sure**
    If yes, what was done and when? _____
    _____

19. Prior to this appointment has endodontic treatment been performed by any doctor?
    Yes / No / Not sure If yes, when? _____

20. Have you ever had any endodontic surgery (apicoectomy) on this tooth? **Yes / No / Not sure**
    If yes, when? _____

21. Are you numb now (been given anesthesia earlier today)? **Yes / No / Slightly / Not sure**

22. Have you taken any antibiotic for this problem?
    No / Today / Last 2 – 3 – 4 – 5 – 6 – 7 days / Last week / Last month / Other: _____
    Name of antibiotic? _____

23. Have you taken any pain killer for this problem?
    No / Today / Last night / Last 2 – 3 – 4 – 5 – 6 – 7 days / Various times
    Name of pain killer? _____

MEDICAL HISTORY

Patient Name: _____

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.

		If Yes, please explain:
Are you under a physician's care now?	☐ Yes ☐ No	
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	
Are you taking any medications, pills, or drugs? IF SO, PLEASE LIST THEM.	☐ Yes ☐ No	
Do you take/have you taken bisphosphonate medication for bone density, osteoporosis, or cancer (ie: Fosamax, Boniva, Actonel, Zometa)?	☐ Yes ☐ No	
Do you use tobacco?	☐ Yes ☐ No	
Do you use controlled substances?	☐ Yes ☐ No	
Do you normally take antibiotics prior to dental visits due to an artificial joint, artificial heart valve, or congenital heart condition?	☐ Yes ☐ No	

WOMEN: ARE YOU…

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other: _____

Please check if you have, or have had, any of the following:

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

Have you ever had any serious illness not listed?

☐ Yes ☐ No If Yes: _____

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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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 _____

- ☐ Root Canal Treatment — Tooth # _____
- ☐ Root Canal Retreatment — Tooth # _____
- ☐ Apicoectomy / Endodontic Surgery — Tooth # _____
- ☐ Other _____ — Tooth # _____

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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

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 evaluation/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 due to previous missed appointments and/or cancellations with less than 24 hours notice.

Non-completion of patient treatment: If treatment is initiated but not completed, 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**

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.

SIGNATURE OF PERSON RESPONSIBE FOR ACCOUNT DATE

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

PRACTICE LIMITED TO ENDODONTICS

11786 S.W. BARNES ROAD, SUITE 230
PORTLAND, OREGON 97225
TELEPHONE: 503-644-4425
FAX: 503-644-4314
WWW.KREUTZERENDODONTICS.COM

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)

_____

_____

_____

David C. Kreutzer, DMD, PC
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 September 1, 2012, 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 detailed voicemail messages at your residence or work regarding appointment time and premedications if needed, postcards, or letters).

Academic Related: We may use or disclose your health information for purposes such as Athletic forms or any other school related health forms.

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 **$0.20** per each page, **$20.00** 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.

Contact Officer: Carrie Benson, office manager
Telephone: 503-644-4425 **Fax**: 503-644-4314
Address: 11786 SW Barnes Rd., Ste. 230, Portland, OR 97225