PATIENT REGISTRATION AND MEDICAL HISTORY FORM

Patient's Full Name: _____ circle⇨ Male Female

Mailing Address: _____ City: _____ State: _____ Zip: _____

Marital Status: circle⇨ M S W D Birth Date: _____ SSN _____

Home Phone #: _____Spouse's Name: _____ SSN _____

Spouse's Birth Date: _____

Person responsible of account: circle⇨ Self Spouse Parent* Other*

*If parent or Other, please list name, address, employer, phone #, S.S.#, birth date and insurance on the back of this sheet.

Your Employer: Name: _____ Address: _____

Phone: _____ Position: _____

Spouse's Employer: Name: _____ Address: _____

Phone: _____ Position: _____

Where may we leave a message: circle⇨ Home Work Other_____

Primary Dental Insurance Company:_____

Carrier (Family Member) _____ Group # _____Agreement # _____

Referring Dentist: _____How long have you been his/her patient?___

Is this Appointment for: circle⇨ Consultation Treatment Both

Have you or any family member been a patient here? circle⇨ No Yes When Who_____

Are you in pain? circle⇨ No Yes

Has your dentist prescribed any medication? circle⇨ No Yes List

Have you previously had a root canal? circle⇨ No Yes When_____

In case of emergency contact _____ *Phone* _____

PERMISSION FOR X-RAYS, CONSULTATION AND/OR ROOT CANAL PROCEDURES

To the best of my knowledge, all answers on this form are correct. I will notify the doctor of any changes in my health or medications.

I, the undersigned, consent to the dental procedures decided upon to be necessary or advisable in the opinion of the doctor, of which I am informed and to which I agree.

I also understand that only the root canal treatment is to be completed at this office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be performed by my general dentist.

How will you be paying for your treatment today?

circle⇨ Visa Mastercard Am. Exp. Discover Check # _____ Cash

SIGNATURE:_____ Date: _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician _____

Date of last physician examination _____ Purpose _____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury	❑	❑
2. allergic reaction to	❑	❑
❑ aspirin ❑ penicillin ❑ erythromycin ❑ codeine ❑ local anesthetic ❑ fluoride ❑ metals (gold, stainless steel) ❑ any other medications_____		
❑ latex ❑ nitrous oxide ❑ sulfa drugs ❑ benzodiazepines (valium, Ativan, etc.)		
3. heart problems	❑	❑
please list _____		
4. heart murmur	❑	❑
5. rheumatic fever	❑	❑
6. scarlet fever	❑	❑
7. high blood pressure	❑	❑
8. low blood pressure	❑	❑
9. pacemaker	❑	❑
10. a stroke	❑	❑
11. artificial prosthesis	❑	❑
please list (i.e. heart valve or joints)_____		
12. anemia or other blood disorder	❑	❑
13. prolonged bleeding	❑	❑
14. emphysema	❑	❑
15. tuberculosis	❑	❑
16. asthma	❑	❑
17. bronchitis	❑	❑
18. sinus problems	❑	❑
19. kidney disease	❑	❑
20. liver disease	❑	❑
21. jaundice	❑	❑
22. thyroid or parathyroid disease	❑	❑
23. hormone deficiency	❑	❑
24. high cholesterol	❑	❑
25. diabetes	❑	❑
26. bruise easily	❑	❑
27. G.E. reflux	❑	❑
28. stomach or duodental ulcer	❑	❑
29. digestive disorders	❑	❑
30. arthritis	❑	❑
31. glaucoma	❑	❑
32. contact lenses	❑	❑
33. head or neck injuries	❑	❑
34. epilepsy, convulsions (seizures)	❑	❑
35. viral infections and cold sores	❑	❑
36. any lumps or swelling in the mouth	❑	❑
37. hives, skin rash, hay fever	❑	❑
38. sexually transmitted disease	❑	❑
39. hepatitis (type _____)	❑	❑
40. HIV / AIDS	❑	❑
41. cancer, type _____	❑	❑
42. radiation therapy	❑	❑
43. chemotherapy	❑	❑
44. emotional problems	❑	❑
45. psychiatric treatment	❑	❑
46. antidepressant medication	❑	❑
47. alcohol / drug dependency	❑	❑
48. dry mouth	❑	❑
ARE YOU:		
45. aware of a change in your general health	❑	❑
46. often exhausted or fatigued	❑	❑
47. subject to frequent headaches	❑	❑
48. a heavy smoker (1 pack or more a day)	❑	❑
49. often unhappy or depressed	❑	❑
50. easily upset or irritated	❑	❑
51. FEMALE - taking birth control pills	❑	❑
52. FEMALE - pregnant	❑	❑
44. FEMALE - breast feeding	❑	❑
53. MALE - Prostate disorders	❑	❑

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment, (include current illnesses, previous surgeries and hospitalizations) _____

_____

List any medications taken within the last two years _____

_____

List any other drugs taken in the past 2 years (steroids, cocaine, recreational drugs, herbal remedies and vitamins...)

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

I certify that I have read & understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient's Signature: _____ Date: _____

Doctor's Remarks: _____

_____ Doctor's Signature _____

Novel Coronavirus Disease (Covid-19) Screening Questionnaire (Please initial next to each response)

1.) ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? _____YES_____NO
2.) DO YOU HAVE A FEVER? _____YES_____ NO
3.) DO YOU HAVE ANY SHORTNESS OF BREATH? _____YES_____ NO
4.) DO YOU HAVE A DRY COUGH? _____YES _____NO
5.) DO YOU HAVE A RUNNY NOSE? _____YES _____ NO
6.) DO YOU HAVE A SORE THROAT? _____YES _____NO
7.) DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES? _____YES_____ NO
8.) HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?_____YES_____ NO
9.) HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL? _____YES _____NO
10.) WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY? _____YES_____ NO
11.) WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED OUTSIDE OF THE FLATHEAD VALLEY? _____YES _____ NO
IF SO, WHERE?_____

_____ Printed Name _____ Date of Birth

_____ Signature _____Date

For Office Use Only:

_____Temperature

_____ Staff Initials

GLACIER VALLEY
ENDODONTICS

Patient Advisory and Acknowledgment Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office for a routine dental evaluation and treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

> While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID 19, we have asked you a number of "screening" questions on the next page. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

_____PATIENT/RESPONSIBLE PARTY _____DATE

_____PRINTED NAME

GLACIER VALLEY
ENDODONTICS

Financial Policy

Payment is due in full at time of service for all procedures. We gladly accept Visa, Mastercard, American Express, Discover, debit cards, checks and cash. For patients without dental insurance a 5% discount is given for cash. Six month, no interest payment plans are available through Care Credit, and Chase Healthcare Financial and are subject to approval from these companies. Applications for these plans can be accessed through our website or by phone: Care Credit - 1 (800) 365-8295 and Chase financial - 1 (800) 510-5638.

If you have dental insurance, 50% of the total is due at the time treatment is rendered, with the exception of Blue Cross/Blue Shield. Payment is due in full at the time of service for patients with Blue Cross/Blue Shield, as they pay the patient back directly. As a courtesy to you, we will gladly process and submit your insurance claim. ***However, if this claim is not paid by your insurance company within 30 days, the balance is your responsibility and due immediately.*** If your account has not been paid in full within 45 days after the date of service, a late charge will be assessed. If there is a balance to you on your account after insurance has paid your claim, a check for the difference will be sent to you. Claims are filed on behalf of our patients for dental services performed in the office to the primary insurance company. Secondary insurance is the patient's responsibility. To assist in filing your secondary claim, we will give you a complete statement of services from our office. Dental insurance benefits belong to you, and it is up to you to ensure that you are receiving appropriate reimbursement under the terms of your plan. There is no guarantee of benefits from the insurance company until a claim is received and processed by the insurance company. Therefore, benefits quoted to you are only an estimate provided by the insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY ME DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

Patient's Name (Printed) _____

Signature of Patient / Guardian _____

Date _____

Appointment Policy

We work closely with our patients to establish a mutual relationship and open communication. With this understanding, we together can work towards maintaining dental health.

Our specialty focuses on treating patients who are in pain and in need of immediate treatment. This makes our appointments very valuable to our patients. We ensure that our patient's needs are fully addressed and give them our sole attention during their appointment time. To make sure this quality of care is maintained, we do not double book appointments like other practices and set aside emergency time so as to not interfere with our regularly scheduled patient's time. When cancellations occur without notice, someone else in pain has lost the opportunity to receive the treatment they need.

Since our appointments are very valuable to our patients, we require 48 hours of notice of a cancellation, so that we can appropriately fill the appointment for someone else in pain. If a minimum of 48 hours is not given, a cancellation fee of $75.00 will be assessed. Due to the extensive preparations made for appointments during the Covid-19 pandemic, any appointments cancelled with less than 24 hours of notice or missed appointments will incur a $200 missed appointment fee. Cancellations must be made during the business week, cancellations made after hours the day before your appointment or over the weekend are not considered to be within 24 hours of notice as the office is closed. If you wish to re-schedule after missing an appointment, a non-refundable deposit of $65.00 for evaluations and $400.00 for surgery or root canal treatment will be required to hold another appointment. This deposit will go towards your patient portion, however will be forfeited if you miss the appointment.

We are committed to providing our patients with highest quality endodontic care in a professional, comfortable, and individualized manner. Your cooperation in keeping your scheduled appointment is greatly appreciated.

Glacier Valley Endodontics, Inc.

Acknowledgement of Receipt of HIPAA Privacy Policies and Procedures

I, _____, have received and reviewed a copy

of_____ [PRACTICE 'S] health information privacy

and security policies and procedures.

Print Name_____

Signature_____

Date_____

GLACIER VALLEY
ENDODONTICS

Endodontic Consent and Information

Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to removed. This is accomplished by the conventional root canal therapy (through the top of the tooth) or when needed, endodontic surgery (performed through the gum). The following discusses possible risks and alternative treatment choices.

General Risks

Included, but not limited to, are complications resulting from performing root canal therapy and the use of dental instruments, drugs, sedation, medicines, analgesics (pain medication), anesthetics, canal disinfectant materials (including sodium hypochlorite, chlorhexidine) and injections. These complications may include: swelling, bruising, sensitivity, bleeding, pain, infection, nerve damage resulting in numbness, itching, burning or tingling sensation in the lip, tongue, chin, gums, cheeks, jaw, face and teeth (which is usually transient, but on infrequent occasions may be permanent), difficulty opening and closing, Temporomandibular Dysfunction resulting in jaw pain, jaw muscle tenderness, reactions to injections, nausea, vomiting, allergic reactions, delayed healing, sinus perforations, and treatment failure.

Other risks include the possibility of instruments broken within the root canals; overextension of the filling material beyond the end of the root; perforations (extra opening) 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 fractures to the crown or root of the tooth. 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.

If the tooth is covered by a crown, I understand that a hole must be drilled through the crown to access the root canal system. I understand that the crown or adjacent teeth/crowns may be damaged in the process, requiring a new crown or repair.

Medications & Other Treatment Choices

Some prescribed medications and drugs may cause drowsiness and lack of awareness and co-ordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs).

Signature_____

It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

Other treatment choices include no treatment, waiting for more definitive development of symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, tooth loss, and spread of infection to other areas of the body.

Consent for Root Canal Therapy

I, the undersigned, being the patient (parent or guardian of minor patient) give consent to Dr. Erin Moseley to perform root canal therapy on the tooth number listed below and any such procedures as may be considered necessary for my well-being based on finding made during the course of root canal therapy. I also consent to the administration of local anesthesia during the performance of root canal therapy.

I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it is a biological procedure and cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

I also understand that upon completion of root canal therapy in this office, I shall return to my general dentist for a permanent restoration of the tooth involved, such as a crown or filling. In some instances the doctor may determine and recommend a permanent restoration be placed after root canal treatment has been completed. I understand that there is a separate fee for this procedure in addition to the fee for root canal treatment. I have also been given the opportunity to discuss the different restoration materials advantages and disadvantages with the doctor and have been given a choice between the different materials to be placed. Fee for Treatment_____

Initials_____

I hereby state that I have read and understand this consent. I have been given the opportunity to ask questions and they have been satisfactorily answered for me and wish to proceed with root canal therapy. This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment. I am medically and physically competent to understand this form and have not taken any mood or mind-altering drugs during the twelve hours prior to signing this document.

$_____. Corrections:_____.
Fee for Treatment

_____.
Tooth/Teeth

Patient Signature:_____ Date:_____.

Witness Signature:_____ Date:_____.

Glacier Valley Endodontics, Inc.
Glacier Valley Dental Imaging, LLC

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/23/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of

supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: Erin Moseley, DMD

Telephone: 406-257-3647 Fax: 406-257-3675

Address: 80 Four Mile Drive, Suite 15; Kalispell ,MT 59901

E-mail: glaciervalleyen@centurytel.net