ENDODONTIC SPECIALISTS of Wisconsin, S.C.

OFFICE POLICY

David W. Belardi, D.D.S.
Bruce R. Hilt, D.D.S.
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F. Kris Olsen, D.D.S.
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Joshua M. Davis D.D.S.

Appointment times are approximate only, because each patient requires and receives individualized attention by the doctor and his staff for whatever time period that may be necessary. The doctor, as a specialist, is, also, confronted with many emergency cases during the day which often delay his schedule. No time clocks are punched when a human health care service is being rendered. Please try to understand if you are asked to wait for the doctor.

Accurate medical histories and a signed consent are required before any work can proceed. The medical history is important for the doctor so that he can tailor his treatment to you dental and physical needs.

It is your responsibility to know what coverage your insurance provides in the area of Endodontics (Root Canal Therapy). **The doctor and his staff are not and cannot be knowledgeable about the coverages of the dozens of health care plans presented for claims.** Medicare does not cover endodontic treatment. Read your policy and know its provisions, as well as its exclusions. You are encouraged to discuss fees with the staff prior to treatment to avoid any misunderstandings.

Our office will assist you in filling your health care claims with your insurance carrier. **However, you are personally responsible for all fees for services provided, not your insurance company.** The insurance company has a contract with you or your employer and not with the doctor. **All fees not covered by your dental or health care plan will be billed directly to you for payment.**

INFORMED CONSENT: The surgical procedure _____ has been explained to me. I give Dr. _____ and /or associates my consent to perform the surgery and other procedures that are necessitated during the course of the planned operation. I understand there may be side effects in connection with these procedures. These include swelling, infection, tingling or permanent numbness of the lips, tongue, gums, or face, post operative bleeding, and discomfort. It is also possible to loosen or damage adjacent teeth and fillings and displace teeth or roots into the sinus.

I agree to the use of local anesthetic, sedation, or analgesia depending on the judgement of the endodontist and that there are risks in the use of any anesthetic agent. I understand that I am not to operate any vehicle or hazardous devices or drink alcoholic beverages until fully recovered from anesthetic.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Signature of Endodontist Date

_____ _____
Signature of Witness Date

In general, we ask that payment for services be made by the first visit. **Patients with dental insurance should realize the insurance programs generally pay only a percentage of the average dental fees for this area. Our practice is exclusively endodontics, our fees may be higher than the average since the cases we see are more than average difficulty and therefore insurance coverage may be slightly less.** Insurance payment will be made directly to the office **and the patient is responsible for any balance. 12% APR interest is added to all account balances over 60 days.**

If you have any concerns about payment, please feel free to discuss them with the doctor.

I am aware of the fees for the services that are being provided by the doctor or doctors of Endodontic Specialists of Wisconsin, S.C. in the amount of $_____.

Past Due accounts will be responsible for all costs associated with trying to collect a debt including a $20 collection fee and all court costs and reasonable attorney fees. A broken appointment fee of $175.00 will be added for any appointment that is cancelled with less than 24 hours notice.

Date: _____ _____
Patient Signature

REGISTRATION

MR.
MRS.
MISS

DATE

DATE OF BIRTH

S M W D

HOME ADDRESS

HOME PHONE

CITY

ZIP

CELL PHONE

EMPLOYER

ADDRESS

SOC SEC NO.

OCCUPATION

WORK PHONE

PREVIOUS ADDRESS

CITY

STATE

PERSON RESPONSIBLE FOR ACCOUNT

ADDRESS

CITY

STATE

REFERRED BY

PHYSICIAN

DENTAL INSURANCE PROGRAM

LOCAL NO.

PURPOSE OF CALL

PREFERRED DAY FOR APPTS.

TIME

AM
PM

REMARKS

OVER →

MEDICAL HISTORY

1. Are you in good health? _____
2. Are you under a physicians care now? _____ if so, please give reason for treatment.

   _____
3. Are you taking any kind of medication at this time? List: _____
4. Please circle any illnesses you have ever had:

allergies	tuberculosis	anemia	kidney or liver	High blood pressure
rheumatic fever	diabetes	heart trouble	asthma	____ Controlled
Infectious hepatitis	epilepsy	glaucoma	AIDS	____ Uncontrolled
				Other

5. Have you ever had trouble with prolonged bleeding after surgery? _____
6. Have you ever had any unusual reaction to anesthetic or drug (like penicillin)? _____
7. Is there any other information that should be known
   about your health? _____
   about your dental visits? _____
8. Have you ever been tested for HIV Virus? _____
   Result: _____
9. Chief Complaint: _____

X _____
Signature

ENDODONTIC SPECIALISTS of Wisconsin, SC

www.endodonticspecialists-wi.com

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PROCEDURE FEE LETTER

Dear Valued Patient:

Endodontic Specialists of WI, SC is pleased to announce that we are now offering the GentleWave® Procedure. This procedure offers superior cleaning and disinfection of your root canal system using a minimally invasive protocol that allows for maximum preservation of your tooth structure. 1,2 In many cases, the GentleWave Procedure or GentleWave Procedure2 for Retreatment can be completed in one appointment. Further, recent published research on the GentleWave Procedure indicates patients may have less discomfort and experience faster healing as compared with a standard root canal treatment. 2

Our Doctors will determine if you are a candidate for the GentleWave Procedure as an alternative to the standard root canal procedure. Your tooth will need to meet certain criteria before we can determine if the GentleWave Procedure is right for you. If your tooth is determined to be suitable for the GentleWave Procedure, Our doctors and our staff will provide you with detailed information explaining the GentleWave Procedure.

Because the GentleWave Procedure does not currently have a specific code for billing your dental plan, your plan will not pay for it. If your plan does not pay, the fee will be solely your responsibility. You will be liable for payment of $75.00.

You should:

1. Read this notice so you can make an informed decision about your care.
2. Ask us any questions that you may have after you finish reading.
3. Choose an option below about whether to receive the GentleWave Procedure. Please initial the first or second option.

- **I want the GentleWave Procedure and will pay for the procedure myself, and not have it billed to my dental plan due to no coverage by ins. Payment may be due now as I am responsible for payment.**

- **I do not want the GentleWave Procedure.**

Signing below means you have received and understand this notice.

_____ _____

Patient Signature Date

Molina B et al. (2105) J Endod. 41:1701–5 2 Sigurdsson A et al. (2016) J Endod. 42:1040-4

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ROOT CANAL TREATMENT CONSENT FORM

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Patient's Name: _____ Record #: _____

Today's Date: _____ Tooth No. _____ Procedure: _____

Risks of Endodontic Treatment

- I understand that many factors contribute to the success of root canal treatment and not all factors can be determined in advance. Some of the factors are: my resistance to infection; the bacteria causing the infection; the size, shape and location of the canals. My case may be more difficult if my tooth has blocked, curved, or narrow canals.
- I understand that root canal treatment may not relieve my symptoms and treatment can sometimes fail for unexplained reasons. If treatment fails, other procedures (including re-treatment or surgery) may be necessary to retain the tooth, or it may have to be extracted.
- I understand that during and after treatment, I may experience some pain or discomfort, swelling, bleeding and loosening of dental restorations. I may also need antibiotics to treat any associated infections.
- I understand that root canal instruments sometimes separate (break) inside the canal which may or may not effect the prognosis. If the separated fragment cannot be retrieved, it may be sealed inside the root canal, or require additional treatment in the future.
- I understand that other risks include perforation by an instrument, sinus perforation and/or nerve disturbances.
- I understand local anesthetic will be given. Some discomfort following treatment may develop from the injection area and from opening my mouth during treatment. On rare occasions, paresthesia of the nerve may occur.
- I understand that once root canal treatment is completed, **I must have a permanent restoration placed by my regular dentist within the next few weeks.** If I fail to have the tooth restored, I risk a failure of the root canal treatment, decay, infection, tooth fracture and/or loss of the tooth.

Alternatives to Endodontic Treatment

Depending on my diagnosis, there may be alternatives to root canal treatment that involve other types of dental care. I understand the most common alternatives to root canal treatment are:

- **Extraction.** I may choose to have this tooth removed. The extracted tooth usually requires replacement by an artificial tooth by means of a fixed bridge, dental implant, or removable partial denture.
- **No treatment.** I may choose to not have any treatment performed at all. If I choose no treatment, my condition may worsen and I may risk serious personal injury, including severe pain, localized severe pain, localized infection, loss of this tooth and possible other teeth, severe swelling, and/or severe infection that may spread to other areas and could be potentially fatal.

I acknowledge that I have provided accurate medical history, will follow treatment recommendations, and have had the opportunity to ask questions about these risks in continuing with root canal treatment.

Patient's Signature: _____ Date: _____

Parent/Guardian: (if minor): _____ Date: _____

Provider's Signature: _____ Date: _____