

Ernest Spergel D.D.S.
Cagatay Erakin D.D.S.
PRACTICE LIMITED TO ENDODONTICS
366 Fifth Ave, Suite 307
New York, NY 10001

Telephone 212-736-3676

Dear New Patient,

Welcome to our practice. We are committed to provide you with the best possible care. We are Root Canal Specialists and our fees reflect our extra training, equipment and experience require saving your teeth.

Our payment policy is as follows:

- 1- Unless your appointment is for a consultation, please anticipate that your root canal treatment will begin on your first visit and a minimum payment of **50%** of fee is required. The balance is required by your last visit.
- 2- Payment for all office services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.
- 3- We accept cash, check, all major credit cards and debit cards. A **\$25** charge will be applied for any checks returned to our office from the bank.
- 4- **Fee for missed appointments:** A specific amount of the time has been set aside for your treatment. In the event that you must cancel your appointment we require 24-hour advance notice. There is a **\$100** charge for all missed appointments without sufficient notice. If you were late more the 20 minutes to your appointment we would reserve the right for rescheduling your appointment.
- 5- **If you have a dental insurance** that our office participates you are required to pay your co-pay or/and deductible at the first visit. Any insurance carrier with whom this office participates may determine a service as ineligible or uncovered; the fee for that service then becomes the patient's liability.

I have read and understood this office policy and realize that all fees, regardless of the insurance coverage, are ultimately my responsibility.

Signature: _____ Date: _____

Please print your name: _____

We look forward to being of service to you. If you have any questions please call our office. Thank You.

PATIENT INFORMATION FORM

Many patients are concerned about the possibility of cross-contamination and infection within the dental office.

Let us assure you that for your protection all American Dental Association acceptable sterilization procedures for dental instruments are utilized in this office. Also, you will note that at times our staff will endeavor to protect ourselves by the use of gloves, face masks and eyeglasses. We have always used disposable injection needles and the anesthetic carpules from each patient are disposed of immediately, and are never reused.

Date: _____ Date of Birth: _____
 Name: _____ Home Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 _____ Social Security No.: _____
 Business Name: _____ Bus. Phone: _____
 Business Address: _____
 Position or Occupation: _____ Referred By: _____
 Dentist Name: _____ Phone: _____
 Address: _____
 Physician Name: _____ Phone: _____
 Address: _____
 Dental Insurance Carrier: _____

MEDICAL HISTORY

(Check if you have ever had the following)

- | | | |
|---|---|---|
| <input type="checkbox"/> PROSTHETIC CARDIAC VALVES | <input type="checkbox"/> REACTION TO CODEINE | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> REACTION TO LATEX | <input type="checkbox"/> STOMACH ULCERS, COLITIS |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> REACTION TO NICKEL OR CHROMIUM | <input type="checkbox"/> CANCER OR CANCER TREATMENT |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> REACTION TO PENICILLIN | <input type="checkbox"/> PROLONGED BLEEDING |
| <input type="checkbox"/> JOINT PROSTHESIS (HIP, KNEE, ETC.) | <input type="checkbox"/> REACTION TO OTHER DRUGS | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> REACTION TO LOCAL ANESTHESIA | <input type="checkbox"/> VIRAL INFECTIONS |
| <input type="checkbox"/> KIDNEY CONDITION | <input type="checkbox"/> REACTION TO BLEACH | <input type="checkbox"/> PURPLISH OR REDDISH AREAS ON SKIN OR IN MOUTH |
| <input type="checkbox"/> LIVER CONDITION | <input type="checkbox"/> CORTISONE THERAPY | <input type="checkbox"/> TMJ PROBLEMS |
| <input type="checkbox"/> THYROID CONDITION | <input type="checkbox"/> BLOOD DISEASE (ANEMIA) | <input type="checkbox"/> PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> PERSISTENT OR SEVERE HEADACHES &/OR MOOD CHANGES |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> HAVE YOU LOST WEIGHT RECENTLY WITHOUT TRYING? |
| <input type="checkbox"/> SHORT OF BREATH | <input type="checkbox"/> DIABETES | <input type="checkbox"/> DO YOU HAVE HIV OR AIDS? |
| <input type="checkbox"/> LUNG PROBLEM | <input type="checkbox"/> SEIZURES, EPILEPSY | |

	YES	NO	IF YES, PLEASE LIST BELOW
Heart Conditions?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Taking Medication?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transfusions? (indicate when)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you required to take antibiotics prior to dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had a root canal treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you presently under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you pregnant or nursing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take birth control pills? (If yes, be advised that if you take antibiotics an alternative method of birth control must be used.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does your occupation place you in a position of contact with whole blood or blood products? (clotting factors, cells, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is there anything else about your medical history I should know?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Root Canal Therapy is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal Therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had Root Canal Therapy may require retreatment, surgery, or even extraction.

ONLY ROOT CANAL THERAPY WILL BE PERFORMED AT THIS OFFICE. THE PERMANENT RESTORATION (FILLING, CROWNING, ETC.) WILL BE DONE BY YOUR REGULAR DENTIST.

Co-pay for any services rendered are due, in full, at or before the completion of treatment, unless other specific arrangements are made.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND GIVE CONSENT FOR THE DOCTOR AND STAFF TO PERFORM THE NECESSARY DENTAL TREATMENT IF NEEDED AFTER THE EXAMINATION ON ME OR MY CHILD.

Signature _____

Witness _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance _____ Group No. _____

Employee _____ DOB _____ SS # _____

Secondary Dental Insurance _____ Group No. _____

Employee _____ DOB _____ SS # _____

PERMISSION FOR DENTAL PROCEDURE(S)

I hereby authorize Dr. _____
to perform upon me or the named patient the following
procedure(s):

The nature and purpose of root canal treatment, and possible
alternative methods of treatment have been explained to me,
and I fully understand them.

I understand that during the treatment I may have periods of
discomfort.

I further understand that many factors contribute to the success
of root canal treatment and cannot be determined in advance.
Therefore, in some cases treatment may have to be discontinued
before it is completed, or may fail following treatment. Some
of these factors are: my resistance to infection, the location
and shape of the canals, etc.

I have been informed that should the treatment have to be
discontinued before completion, or if it fails following
treatment, other procedures may be necessary to save the tooth,
including surgery, or it may have to be extracted.

I further understand that during and following the treatment, I
am to contact the doctor's office if I have any additional
questions, or I experience any unexpected reactions.

I acknowledge that no guarantee or assurances have been given
by anyone as to the results that may be obtained.

I have discussed all of the above with the doctor, and have had
all my questions answered.

Patient/Relative or Guardian *

Signature

Print Name

Date

Relationship (if signed by person other than patient)

Interpreter (if used)

Signature

Print Name

Date

Witness:

Signature:

Print Name:

Date

* The signature of the patient must be obtained unless the
patient is an unemancipated minor (under the age of 18) or
is otherwise incompetent to sign.

Dentist Certification

I hereby certify that I have explained the nature, purpose,
benefits, risks of, and alternatives to (including no treatment
and attendant risks), the proposed procedure(s). I have offered
to answer any questions and have fully answered all such
questions. I believe that the patient/relative/guardian fully
understands what I have explained and answered.

Dentist's Signature

Print Name Date

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE
PATIENT'S DENTAL RECORD.

PATIENT HIPAA AWARENESS

With my permission, Drs. Erakin & Spergel may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Drs. Erakin & Spergel's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Drs. Erakin & Spergel reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Drs. Erakin & Spergel may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Drs. Erakin & Spergel may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Drs. Erakin & Spergel may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Drs. Erakin & Spergel restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Drs. Erakin & Spergel to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian