CARY ENDODONTICS

WILLIAM C. WINDLEY III, DDS, MS, PA

PRACTICE LIMITED TO ENDODONTICS

Patient Information

Date ________________________ Primary General Dentist ____

Name: First ___________________________ Middle ______________________Last __________________________

Address ____

City __________________State ____________ Zip Code ___________ Email ________________________________

Home Phone ____________________ Business Phone ___________________ Cell Phone ______________________

Birth Date ________________ Sex: ☐ M ☐ F Social Security # ___________________________________

Patient Employed By _______________________________________ Occupation _____________________________

Business Address ____

Emergency contact/ phone number ____

Dental Insurance

Subscriber Name ______________________________ Relation to Patient ______________Birth Date _____________

Address (if different from patient's) ____ Phone _____________

Subscriber Employed By _______________________ Occupation _______________ Social Security # _____________

Business Address ____ Business Phone _____________

Insurance Company ____ Insurance Co Phone _____________

Insurance Co. Address ____

Group # _____________________ Subscriber # _______________________

Secondary dental insurance coverage:

Subscriber Name ______________________________ Relation to Patient ______________ Birth Date _____________

Address (if different from patient's) ____ Phone _____________

Subscriber Employed By _______________________ Occupation _______________ Social Security # _____________

Business Address ____Business Phone _____________

Insurance Company ____Insurance Co. Phone _____________

Insurance Co. Address ____

Group # ____________________ Subscriber # _________________________

Cary Endodontics

William C. Windley III, DDS, MS, PA

Practice Limited to Endodontics

Medical History

Patient Name ____ Birth Date __________________________

Are you under the care of a physician? Yes No If so, name of physician ______________________________

Have you had a serious illness, operation, or been hospitalized in the past five years? Yes No

Do you have, or have you ever had, any of the following diseases or medical conditions, or medical procedures?

If yes, place a check in the corresponding box.

Heart murmur	Asthma	Diabetes
Heart attack	Hay fever	Glaucoma
Angina	Emphysema	Hepatitis
Rheumatic Fever	Tuberculosis	Kidney Disease
Damaged Heart Valves	Bronchitis	HIV / AIDS
High blood pressure	Sleep Apnea	Epilepsy
Low blood pressure	History of drug abuse	History of alcohol abuse
Heart Surgery	Anemia	Prolonged bleeding
Cardiac pacemaker	Stomach ulcers	Blood disorders
Stroke	Chronic fatigue	Mental health problems
Chest pain	Cancer	Radiation / Chemotherapy
Arthritis	Thyroid Disease	Immunosuppression

Medications

Are you taking, or have you taken, any of the following medications?

Anxiety medication	Pain medication	Insulin
Blood thinners	Aspirin	Antidepressants

Bone density medications or Bisphosphanates (Aredia, Zometa, Fosamax, Actonel)

Please list all medications you are currently taking ____

____

____

Allergies

Are you allergic to or suffer ill-effects from the following medications or materials?

Penicillin	Amoxicillin	Clindamycin
Aspirin	Codeine / Hydrocodone	Latex
Sulfa drugs	Local anesthetic	Other ______________________

Oral Sedation

Are you interested in taking an oral anti-anxiety medication if treatment is required? Yes No

If so, are you taking any of the following medications or supplements?

Grapefruit Juice	Diltiazem (Cardizem)	Verapamil (Calan, Isoptin)
Clarithromycin (Biaxin)	Fluconazole (Diflucan)	Itraconazole (Sporonox)
Nefazodone (Serzone)	Tetracycline (Doxycycline)	Cimetidine (Tagamet)
Omeprazole (Priolosec)	Esomeprazole (Nexium)	Fluoxetine (Prozac)

Antibiotic Premedication

Do you require antibiotic premedication prior to dental treatment? Yes No Do you have, or have you ever had, any of the following conditions or treatments? bacterial endocarditis, prosthetic heart valve, congenital heart disease, cardiac transplant, prosthetic joint replacement, previously infected prosthetic joint Yes No

For Women Only

Are you pregnant? Yes No Expected delivery date __________ Is there a possibility of pregnancy? Yes No

Are you nursing? Yes No Are you taking birth control medication? Yes No

Note: Antibiotics may alter the effectiveness of birth control medication. Please consult your physician or gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the questions above. I affirm that the above information is accurate to the best of my knowledge.

Print Name ______________________________________

Signature ____

Date ____

Reviewed by ____________________________________ Date _________________________

Cary Endodontics
WILLIAM C. WINDLEY III, DDS, MS, PA

Practice Limited to Endodontics

Office Payment Policy

The best doctor/patient relationships are maintained when there is complete understanding of the treatment rendered and the fee charged. Our goal is to provide you with excellent endodontic care. Our fees are based on this quality of care, the complexity of your case, and the number of visits required to complete your treatment. It is not always possible to determine all necessary services and costs prior to the initiation of treatment. **Although an estimate of the cost of services has been provided, actual charges may vary and will be based on the services provided.**

We accept cash, personal checks, Master Card, Visa, and Discover Card.
Please check the payment option you prefer:

☐ Cash

☐ Personal Check (Funds will be verified)

☐ Credit Card (Master Card/Visa/Discover)

Insurance Policies

There is no direct relationship between this office and your insurance company. The type of plan chosen by you and/or your employer determines your insurance benefits; **dental insurance policies vary**. While it is your responsibility to understand your insurance policy, we will make every effort to help you understand and maximize your insurance benefits. We are not responsible for the accuracy of any estimation of your insurance coverage. This is strictly between you and your insurance company. Any insurance benefit explanations given by our staff are only estimates. They are not a guarantee of benefits or payment.

For patients with dental insurance: Payment in full is required on the day service is rendered for evaluation appointments, emergency treatments, internal bleaching, and treatment of traumatic injuries being filed through medical insurance. As a courtesy to our patients, we accept assignment of benefits for most insurance companies for conventional root canal treatments, endodontic retreatments, and endodontic surgeries. With proof of insurance, we will contact your insurance company and obtain an estimate of your benefits. We will then calculate the amount that you will be required to pay on the day of treatment. This is only an initial estimate and may change if the actual treatment is different than anticipated. An insurance claim will be generated and submitted for you once treatment has been completed. You will be responsible for the remaining balance, regardless of insurance estimates, coverage, and/or payments. Overdue accounts will be charged a finance charge of 18% annually. Overdue/unpaid accounts will be subject to collections actions. The patient or guardian will be responsible for collections agency, attorney, court, and all associated fees incurred by William C. Windley III, DDS, MS, PA.

If during endodontic treatment, your tooth is found to be untreatable due to fractures, gross decay, calcifications, etc.; you will be charged a fee for incomplete endodontic therapy. This must be paid in full at the time of service, since this service is not always covered by dental insurance.

For patients without dental insurance: Payment in full is required on the day service is rendered.

Broken Appointment Policy

Your appointment time has been reserved especially for you. If you are unable to keep your appointment, please notify us at least 48 hours in advance. This notice must be given Monday – Thursday. As a courtesy to our patients we will attempt to confirm your appointment, but it is the patients (parents or guardians) sole responsibility to keep scheduled appointments. **Broken appointments or appointments cancelled with less than 48 hours notice may require a non-refundable deposit to schedule future appointments.**

Office Fee Policy

A fee of $25.00 will be charged for insufficient funds/ returned checks.

I understand and agree to these office policies. Signature of patient (parent or guardian):

X____ Date: ___________________________

Cary Endodontics
WILLIAM C. WINDLEY III, DDS, MS, PA

Practice Limited to Endodontics

ENDODONTIC INFORMATION AND CONSENT

Please be assured that we use accepted infection control procedures and universal precautions for the protection of our patients and staff.

Endodontic Root Canal therapy, Endodontic Surgery, Anesthetics, and Medications
While serious complications associated with root canal therapy are very rare, we would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy or, when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment, and other treatment choices.

Risks: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections. These complications include swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth – which is often transient but, on infrequent occasions, may be permanent; reaction to injections; changes in occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations; and treatment failure.

Risks More Specific to Endodontic Therapy: The risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing teeth, fillings, crowns, or porcelain veneer; 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 or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), and splits or fractures of the teeth.

Medications: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

Women Taking Birth Control: Antibiotics may decrease the effectiveness of birth control medication. Please take necessary precautions.

Other Treatment Choices: These include no treatment, waiting for more definite development of symptoms, or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

Consent:
I, the undersigned, being the patient (parent or guardian of above minor patient), consent to the taking of diagnostic radiographs and the performing of examinations and procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that **upon completion of root canal therapy in this office, it is imperative that I return to my general family dentist for a permanent restoration** (crown, onlay, composite or amalgam) of the tooth involved **within 3-4 weeks**. I understand that root canal treatment is an attempt to save a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, **it cannot be guaranteed. Approximately 5%-15% of teeth receiving endodontic therapy may require further treatment or extraction.**

________________________________ ____________________________
Patient, parent, or guardian Date

________________________________ ____________________________
Witness Date

Cary Endodontics
WILLIAM C. WINDLEY III, DDS, MS, PA

Practice Limited to Endodontics

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 January 1, 2003, 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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders. We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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 practically 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 $10.00 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 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 complain 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. We will make every effort to reconcile any written complaints filed directly with our office.

CARY ENDODONTICS
HIPAA officer: Office Manager
2637 Green Level West Road
Cary, NC 27519
(919) 468-1435

U.S. Department of Health & Human Services
Office of Civil Rights
Washington, DC 20201
(202) 619-0257
Toll Free: 1-877-696-6775

CARY ENDODONTICS
WILLIAM C. WINDLEY III, DDS, MS, PA

PRACTICE LIMITED TO ENDODONTICS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that, under the Health Insurance Portability & Accountability act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Inquire about sufficient funds and obtaining payment.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I have the option to refuse to sign this acknowledgement.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ______________________________

Relationship to Patient ______________________________

Signature ______________________________

Date ______________________________

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) ______________________________