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
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) _____

CARY ENODODONTICS 2637 High House Rd
Practice Limited to Endodontics & Microsurgery Cary NC, 27519
William C Windley III, DDS, MS, PA

Informed Consent CBCT Scan

1**. A CBCT scan, also known as Cone Beam Computed Tomography imaging**, is an x-ray technique that produces 3D images of your skull that allows visualization of internal bony structures in cross section rather than as overlapping images typically produced by conventional x-ray exams. CBCT scans are primarily used to visualize bony structures, such as teeth and your jaws, not soft tissues such as your tongue or gums. CBCT has become the Standard of Care for endodontic treatment.

2**. Benefits: Using a CBCT scan instead of conventional x-rays has certain advantages.** A conventional x-ray of your mouth limits your dentist to a two-dimensional visualization. Diagnosis and treatment planning can require a more complete understanding of complex three-dimensional anatomy. The relationship of anatomical structures in three dimensions is important in assessing your condition as well as treatment planning for dental implants, surgical extractions, endodontic treatment, oral surgery, or advanced dental restorative procedures. CT scans may be useful in evaluating and potentially diagnosing conditions that cannot be properly seen with conventional x-rays.

3**. Risks:**

• **Radiation:** CBCT scans, like conventional x-rays, expose you to radiation. The dose of radiation used for CBCT examinations is carefully controlled to ensure the smallest possible amount is used that will still give a useful result. However, all radiation exposure is linked with a slightly higher risk of developing cancer. The advantages of the CBCT scan outweigh this disadvantage.

• **Pregnancy:** Women who are pregnant should not undergo a CBCT scan due to the potential danger to the fetus. Please tell the dentist if you are pregnant or planning to become pregnant.

• CBCT scans cannot be relied on to show soft tissue lesions unless they have caused changes in your hard tissues (teeth or bone).

4**. Alternatives:** An alternative to a CBCT scan is conventional dental x-rays, however, they have the limitations previously noted.

5.**Diagnosis of non-dental conditions:** CBCT scans image the entire head and most of the neck. As dentists, we evaluate teeth, jaws and surrounding bone, using the CBCT for those limited purposes. Our training and dental license do not provide for evaluation and diagnosing outside of those areas. We are not physicians or radiologists. While parts of your anatomy beyond your mouth and jaw may be visualized in the scan, your dentist is not qualified to diagnose conditions that may be present in the head and neck areas. By signing this form, you are acknowledging that the CBCT scan will be evaluated solely for the dental purposes of the scan.

6. **Jewelry: All jewelry from the neck up needs to be removed prior to being taken back.**

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT, AND AGREE TO ACCEPT THE RISKS AND ADVANTAGES NOTED.

I, _____being 18 years or older, certify that I have read the above statement. I understand the procedure to be used and its benefits, risks, and alternatives. I have been given the opportunity to have my questions answered, and accept the risks of the CBCT scanning procedure as described above. I therefore give my consent to have Dr. Windley and the staff as they may designate, perform a CBCT scan. **I understand the cost of $205 is usually not covered by dental insurance and is my responsibility.**

Signature of Patient, or Legal Guardian _____Date_____

Witness to Signature_____Date_____