1401 Fountain Park Circle | Brunswick, Georgia 31520
912.265.0001 | www.hooperendo.com

Jason T. Hooper, DMD

PATIENT REGISTRATION

Title: Mr.___ Mrs.___ Miss___ Ms.___ Dr.___ Other___

Name: First____________________________MI____Last________________________________

Gender: M____ F_____ DOB: ___/___/___ SSN: ______ -____ -______

Home Ph# ______________________________ Cell Ph# _________________________________

Address: ____

City, State:____ ZIP:__________________________

Email: ____ Pharmacy:_________________________

Emergency Contact: __________________________ Relationship: _______________________

Emer. Contact Ph. # _________________________ General Dentist ______________________

Insurance: _____________________________ Employer: ____________________________

Consent for Use and Disclosure of Health Information and Release Form
Our practice has always safeguarded and protected our valued patient's personal and health information. These safeguards meet or exceed the 2003 H.I.P.A.A (*Heath Insurance Portability and Accountability Act*), under the *Department of Health and Human Services* requirements to include the September 2013 "*Omnibus*" updated privacy regulations. Our practice privacy policies, in accordance, allows us to use your personal information for "Normal and Customary" services when required communication within the Healthcare profession, both clinical and administrative to include but not limited to: Consultations with another Healthcare profession such as your medical doctor or another dental specialist about your treatment or progress, assisting with patient insurance, appointment reminders, account financial information and laboratory cases.
HIPAA Contacts- Please specify anyone you authorize our Practice to release information and what type of information we may give out, if requested and approves, about you, your treatment, progress or account. Usually this is a spouse or significant other, parent or guardian, grandparents, adult children or whomever you choose to authorize our Practice and Healthcare Associates to release information to.
PLEASE PRINT COMPLETE NAME(s) AND LEGAL RELATIONSHIP TO PATIENT.

Patients under the age of 18 will not be treated unless accompanied by a parent or a legal guardian.

We would like to thank you for allowing us to treat you today. The following is our office policy on payment and insurance:

- **If Hooper Endodontics is NOT in network with your insurance company, PAYMENT MUST BE PAID IN FULL AT THE TIME OF SERVICE. We will then file your insurance as a reimbursement to be paid to you directly.**
- **IT IS YOUR RESPONSIBILITY to find out if Hooper Endodontics IS IN OR OUT OF NETWORK with your insurance.**
- **The estimate you are given is based on what we charge, NOT what your insurance pays. After we receive payment from insurance ANY REMAINING BALANCE WILL BE YOUR RESPONSIBILITY.**
- **IF YOU DO NOT HAVE INSURANCE, PAYMENT IN FULL IS REQUIRED AT THE TIME OF SERVICE.**
- **Any account not paid in full within 90 days of billing will be considered delinquent and is subject to collection. Any account turned over to a collection agency will incur 35% collection fee pursuant in Georgia Statutory Law O.C.G.A. 13.1.11.**

APPROXIMATE FEE SCHEDULE:

Consultation:	$*95 - $120*	Anterior Root Canal:	$*840*
Emergency Treatment:	$*150*	Bicuspid Root Canal:	$*940*
Permanent Filling:	$*200 - $295*	Molar Root Canal:	$*1140*
X-Ray:	$*25*	Anterior Apicoectomy:	$*1010*
Post Removal:	$*210*	Bicuspid Apicoectomy:	$*1110*
Nitrous Sedation:	$*85*	(each additional root):	$*200*
Calcium Hydroxide:	$*115*	Incomplete Root Canal:	$*350*
Calcified Root or retreatment of existing Root Canal additional:			$*100*

***Upon completion of your root canal, any necessary final restoration will be charged separately. This procedure is not considered part of the root canal.**

Please choose below how you will be paying today and sign below, indicating you have read and understand the above payment policy of Hooper Endodontics, and are in full compliance. Your signature also authorizes release of information necessary to file your insurance claim.

_____Credit card ____Debit Card ______Check _______Care Credit _____Cash

PATIENT SIGNATURE______________________________________ Date__________________________

PARENT/GUARDIAN SIGNATURE____Date___________

MEDICAL HISTORY (Please circle all that apply)

EARS/EYES:

Deafness Vertigo Tinnitus Blindness Macular Degeneration

RESPIRATORY:

Asthma Lung Cancer Respiratory Failure COPD Emphysema

Tuberculosis: _____active _____non-active

CARDIAC:

Angina Irregular Heartbeat Atrial Fibrulation Heart Attack Mitral Valve Prolapse

GASTRO-INTESTINAL:

Ulcers Reflux Disease (GERD) Occasional Acid Reflux/Indigestion

URINARY/RENAL:

Dialysis Kidney Disease Sexually Transmitted Disease

VASCULAR:

Blood Thinner High Blood Pressure Low Blood Pressure

MUSCULOSKELETAL:

Osteoporosis Bone Medication TMJ/TMD/Jaw Clicking

HEMATOLOGIC:

Anemia Bruise easily HIV/AIDS Hepatitis type______

CANCER:

Type:____________________Chemotherapy Radiation- Current Past

NEUROLOGICAL

Frequent Headaches Migraine Headaches

ENDOCRINE:

High Thyroid Low Thyroid Diabetes Autoimmune Disease

PSYCHIATRIC:

Anxiety Disorder Depression Bipolar Disorder History of Substance Abuse

Please initial if none of the above apply: _________

Dr. Hooper ________

Please fill out the following health history as accurately as possible. Some health issues and medications could impact your treatment.

Other than the tooth we are treating today, please describe below any other unhealed areas or growths in or around your mouth, or if you have recurring fever blisters: ____________________

Do you have any current health conditions impacting your treatment today? Yes No

Please explain: (i.e. any recent surgeries or illnesses in the last 2 years.)

____

Do you have a prosthetic joint? Yes No **Date of placement:** (Mo/year)________

Heart Valve Replacement? Yes No **Congenital Heart Defect?** Yes No

***Are you required to pre-medicate due to a joint replacement or a heart valve replacement?** Yes No

Do you smoke? Yes No

Women: Are you pregnant or nursing? Yes No

MEDICATION: Please list all current medications, including over the counter supplements, etc.

ALLERGIES: Are you allergic to or have had a reaction to any of the following?

Local anesthetics such as Novocaine, Lidocaine, etc.? Yes No
Latex/Latex products Yes No
Penicillin Yes No
Other antibiotics Yes No

List other allergies: ____________________

____

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CONSENT FOR ENDODONTIC TREATMENT

Patient's Name ______________________________

Condition Treated ______________________________

Proposed Treatment ______________________________

Endodontic therapy (root canal, apical surgery) involves performing a procedure to retain a tooth, which may otherwise require extraction. The treatment involves relieving pain and discomfort by removing inflamed and/or infected tissue within and around the roots of the teeth. Although endodontic therapy has a very high degree of clinical success, many factors contribute to its success or failure, which may not be determined in advance. Therefore, a tooth, which requires or even has had root canal therapy, may require retreatment, surgery, or even extraction. Some of these factors affecting outcome include, but are not limited to: the body's resistance to infection; the location and anatomy of the root canal system; periodontal (gum) disease; a tooth fracture that either went undetected or occurred after the treatment; failure to keep scheduled appointments; or the failure to have the tooth restores promptly or appropriately after completion of the treatment. These factors may cause a tooth to be lost even after treatment has been completed and appears initially successful.

By signing this form I understand that complications of endodontic therapy may include, but are not limited to: the possibility of instruments broken within the root canals which may deem the case a failure, requiring subsequent extra-perforations (extra openings) of the crown or root of the tooth; damage to existing fillings, crowns or bridges; fracture the tooth; discomfort; jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty; swelling and pain; other severe general health complications. During and after treatment, complications may be discovered which make treatment impossible or which may require endodontic surgery or even extraction of the tooth. This additional treatment usually requires further fees as well.

I understand that complications of anesthesia, injection, prescribed analgesics (pain relievers) and medicines may include but are not limited to: swelling, infection, bleeding, discoloration of the face, bruising, discomfort, pain, nausea, drowsiness, allergic reactions, numbness or tingling of the lip, gums or tongue (usually temporary).

I have been informed of possible alternative treatment methods including extraction or no treatment at all.

Every reasonable effort will be made to ensure that your condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment and its alternatives, that you understand this information, and that all of your questions have been answered fully.

By signing below, I give my consent for the proposed treatment as described above.

____

Patient signature **Date**

(Parent/Guardian signature if patient is a minor)