L. Stephen Buchanan, DDS, FICD, FACD

Practice Limited to conventional and microsurgical Endodontics
Diplomate of the American Board of Endodontics

Medical History Form

Personal Information:

Salutation:	First Name:	Last Name:	M.I.
Home Phone:	Cell Phone:	Date of Birth:	
Work Phone:	Fax:	Gender:	
Home Address:	City/State/Zip:		
Employer Name:	Occupation:		
Employer Address:	Social Security #		
Referring Doctor	Family Dentist:		
Home E-mail:	Work E-mail:		

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Insurance Information

Dental Insurance Co:	ID#	Group#
Insurance Claims Address:		
If you are a dependent of the subscriber		
Subscriber Name:	Subscribers Social Security #	
Subscribers DOB:	Subscriber Relationship:	
Subscriber Employer:	Coverage From:	

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	Yes	No	Unknown
1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?			
2. Has There been any change in your health with in the past year? If yes, please explain:			
3. Are you under the care of a physician for a current problem? If yes, Please specify:			
4. Have you been hospitalized with in the past 5 years? If yes, please specify:			
5. Have you received therapy for alcoholism or drug addiction during the past 5 years?			
6. Have you ever had an ALLERGIC reaction ADVERSE REACTOINS to anesthetics/antibiotics/medications? Please specify:			
7. Is there any condition concerning your health that the doctor should e told? Please specify:			
8. Do you wish to speak with the doctor privately about anything?			
9. Have you had abnormal bleeding with previous extractions, surgeries or trauma?			
10. Have you ever required a blood transfusion?			
11. Have you ever had surgery and/or radiation for a tumor, growth, or other conditions?			
12. Have you ever tested positive for HIV infection or AIDS? If so, date diagnosed and the treating doctor:			
13. Are you required to take antibiotics prior to dental treatments?			

14. Have you had any of the following? If yes, please check the box below.

High Blood Pressure		Sinus Trouble	
Heart Murmur or prolapsed valve		Thyroid Problems	
Joint Prosthesis (hip, knee, etc.)		Diabetes	
Rheumatic Fever/Rheumatic heart Disease		Stomach Ulcers, Colitis	
Congenital Heart Disease		Hepatitis, Jaundice, Liver Disease	
Cardiovascular Disease		Kidney Problems	
Prosthetic Heart Valve		Psychiatric Treatment	
Blood Disorder (e.g., Anemia)		Fainting Spells or Seizers	
Venereal Disease		Epilepsy	
Asthma		Cancer	
Allergy to Latex		Temporomandibular Joint Problems	
Low Blood Pressure		Low Blood Sugar	

Chest Pain		Dialysis	
Swollen Ankles, Arthritis or Joint Disease		Irregular Heart Beat	
Cardiac Pacemaker		Contagious Disease	
Heart Surgery		Bronchitis, Chronis Cough	
Delay In Healing		Hay Fever or Sinus Problems	
Tuberculosis		Problems with Immune System	
Emphysema		Difficult Breathing or other lung issues	
X-ray treatment or Chemotherapy		Chronic Fatigue or Night Sweats	
On a diet		History of Drug Abuse	
History of alcohol abuse		Wear Contact Lenses	

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Eye Disease or Glaucoma		Bruise Easily	
Infectious Mononucleosis		Gallbladder Trouble	

15. Are you taking any herbal medicine (i.e., St. Johns Wort)?			
16. Have you ever taken Fen-Phen?			
17. Do you have any disease, condition, or problem not listed above? Please specify:			
18. Are you taking any Medications or drugs? Is yes, please list them with times per day and milligrams.			

Women Only

Possibility of pregnancy? Yes/No	Nursing? Yes/No
Estimated Delivery Date:	Taking birth control pills? Yes/No

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of control.

If this visit is related to an injury, fill out the fields below

Accident Related		Work Related	
Date of Injury:		Claim Number:	
Insurance Company Handling Claim:			
Name of Attorney/Adjuster:			
Attorney/Adjuster Phone #:			

Physicians Info	Emergency Contact
Physicians Name:	Name:
Physicians Phone:	Work Phone:
Specialists Name:	Home Phone:
Specialists Phone:	

_____ _____.

Patient Signature (Parent Signature if patient is under the age of 18) Date

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Pain History

	Yes	No	Unsure
1. Have you ever experienced pain in this tooth at any time in the past?			
2. Are you in Pain now?			
3. If you are in pain now, how long has it been? Please Circle One 1 Day, 2 Days, 3 Days, 4 Days, 5 Days, 6 Days, 1 Week, 2 Weeks, 3 Weeks			
4. Did this pain keep you awake or awaken you last night?			
5. Can you locate the tooth that is causing the pain?			
6. Does the pain radiate to other parts of your jaw or down your neck and shoulders?			
7. Is the pain Spontaneous or does it always require some stimulus to become painful?	Spontaneous		
	Requires Stimulus		
8a. Do you feel swollen?			
8b. Has there been any history of prior swelling?			
8c. Are you running a fever?			
9. How would you rate your severity of your pain today? 1-10 scale 1=very slight 10=Unbearable	1 2 3 4 5 6 7 8 9 10		
10. Do you have lingering pain? (More than a few seconds)			
11. Please describe the frequency and nature of pain that most closely describes your discomfort, by circling all those that apply.	Sharp, Dull, Radiating, Variable, Throbbing, Tingling, Constant, Migrating, Enlarging to other areas, Shooting, Itching, Aching, Intermittent, Momentary, Burning, Only when chewing or biting		
12. Is the tooth sensitive to temperature?			
13. What relieves the pain? Please circle all that apply.	Nothing, Cold, Hot, Massage, Vicodin, Non-Biting, Aspirin, Advil, Excedrin, Aleve, NSAIDS, Codeine, Antibiotics, Darvon, Other		
14. If you don't touch the tooth or bite on it, does it still hurt?			
15. What increases the pain? Please circle those that apply.	Touching, Biting, cold, hot, Eating, Cold Air, Lying Down, Pressing on the Gum, Flossing, Sweets, Nothing		
16. What is the course of the pain? Please circle those that apply.	Increasing, Decreasing, Constant, Variable, None		
17. Has there been any recent restorative work done on this area?			
18. Prior to this Appointment has any endodontic treatment been started by another doctor?			

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19. Have you had recent periodontal (gum) surgery in the area or a tooth cleaning?			
20. Have you ever had endodontic surgery on this tooth?			
21. Are you numb now?			
22. Have you taken any antibiotics for this problem?			
23. Have you taken any pain killers for this problem?			
24. Did you explicitly request this referral?			
25. Did your doctor recommend this referral?			

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Office Financial Policy Disclosure and Consent

Payment Policy:

Payment is due upon arrival in our office before treatment is started. The payment for services may be made by cash or check. We accept Visa, MasterCard, American Express or Discover credit cards.

Dental Insurance:

The office of L. Stephen Buchanan, DDS will act as facilitator in the claims process as a courtesy, and is not responsible for provider determinations, errors, or omissions in the processing of a claim.

The office of L. Stephen Buchanan, DDS is not contracted with any one insurance, our office will bill your insurance as a courtesy, and may decline to do so. Please note, any reimbursement by your insurance will be remitted to you directly.
The payment made at the time of service is **strictly an estimate**. Any additional fees or outstanding balance for the treatment or procedure will be addressed to the responsible party and responsibility to pay.
Please be advised that our fees for services may differ from the coverage limit set by your insurance provider.

It is the patient/insured's *responsibility* to know insurance policy in opting for a Out of Network Provider, what treatments are covered by their policy, and what insurance contribution will be for any treatment or procedure.

If your insurance company denies any part of your claim, payment will be your responsibility.

Cancellation Policy:

The office of L. Stephen Buchanan enforces a 48-hour cancellation policy. Cancellations made less than 48-hours prior to the scheduled appointment may result in a fee of $175.00. Patient's failure to appear for a scheduled appoint **will** result in a $175.00 cancel fee.

I understand and agree to this Financial Policy on this date_____.

_____ Patient's Signature

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NOTICE OF PRIVACY PRACTICE

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, 2004 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.

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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 institution or law enforcement official having lawful custody of protected health information of inmate or patient 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 must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time .

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 abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments 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 complaint 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.

I have read and agree to your privacy policy:

Print Name: _____

Signature_____

Date_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For 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)

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

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INFORMATION AND CONSENT FORM

Before starting endodontic (root canal) treatment, you should be informed of all the risks and alternatives to endodontic treatment. You will be required to sign this consent prior to the initiation of treatment. However, signing this document does not commit you to treatment. **This consent serves to acknowledge that you have been informed and understand the following regarding your treatment:**

Root canal treatment is an attempt to retain a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth that has had root canal therapy may require retreatment, microsurgery, or extraction.

The alternatives to endodontic treatment include: no treatment, waiting for more definitive development of symptoms; and extraction of the tooth. Risks involved in these choices might include pain, swelling, infection, loss of tooth or teeth, and infection to other areas.

Risks of endodontic treatment are of two kinds: those risks associated with general dental procedures and those risks specific to endodontic treatment.

Risks of general dental procedures: 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 pain, infections, swelling, bleeding, sensitivity, numbness, and tingling sensation (transient or permanent) in the lips, tongue, chin, gums, cheeks and teeth, thrombophleblitis (inflammation to the vein), reaction to injections, change in occlusion (biting), muscle cramps, spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restorations in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruising, delayed healing, sinus complications and further surgery. Prescribed medication and drugs may cause drowsiness, and lack of awareness and coordination (which may be influenced by the use of alcohol and other drugs) thus, is advisable not to operate any vehicle or hazardous device, or to work for twenty-four hours or until recovered from their effects. Antibiotics may interfere with oral contraceptives, so an alternative means of birth control should be planned for your entire cycle that month.

Risks specific to endodontic therapy: These risks include instruments broken within the root canal(s), perforations (extra openings) of the crown or root of the tooth, damages to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals and fracture of tooth structure. During treatment, complications may be discovered which make treatment impossible, or may require microsurgery. These complications may include: blocked or obstructed canals resulting from fillings, prior treatment, natural calcification, broken instruments, curved roots, periodontal disease (gum disease) and cracks or fractures of the teeth. It is suggested that when drilling through a porcelain crown, the crown be replaced due to micro fractures created during the drilling process. At times there may be complete fracture of the porcelain crown. Our office assumes no financial responsibility for the replacement of these crowns.

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CT Scan: The CT-Scan used in our office is an excellent tool for the detection of infections associated with root canals, however it is not diagnostic for the detection of decay. Conventional radiographs should be taken at your dentist office for the detection of decay.

For those patients who have been referred to our office for a CT Scan only, a consultation with one of our doctors is **not part of this appointment**. Our office should be considered strictly as an imaging center. We do not review, diagnose, or render opinions to these patients. This is the responsibility of your referring doctor.

PLEASE SIGN IN THE SPACE BELOW UNLESS YOU HAVE QUESTIONS FOR THE DOCTOR.

If there is anything you do not understand about the endodontic procedure, or any statements in this form, or if you still have any questions after reading this form, please discuss them with the doctor before signing below. Thank you.

Signature _____ Date _____

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Disclosure Regarding Financial Interest in Dental Companies
Dental Instruments and Products

During the course of consultation, treatment, or the provisions of services, the offices of Dr. L. Stephen Buchanan, DDS, may use products for which he owns a financial or intellectual property interest. Such ownership or financial interest includes, but may not be limited to the following:

- Dr. Buchanan serves in an advisory capacity as a paid consultant;
- Dr. Buchanan receives royalties for intellectual property for product; ownership, licensing or development;
- Dr. Buchanan may receive compensation for the endorsement for certain products;
- Dr. Buchanan may have an equity interest in the company manufacturing certain products.

Companies and products that Dr. Buchanan currently has a financial interest include:

1. Kerr Endodontics
2. Acteon
3. Obtura Spartan Endodontics
4. Dentsply Tulsa Dental Specialties
5. Dental Engineering Laboratories, LLC
6. DELabs
7. Terauchi File Retrieval Kit (TFRK)
8. Elements Obturation Unit
9. Buchanan Hand Pluggers
10. Buchanan System B Heat Pluggers
11. LA Axxess Kit
12. Spartan Ultrasonic Tips
13. GT Files, GTX Files and associated GT Products
14. PlanB Dental
15. Vista Apex

It is the patient's responsibility to inform the office of Dr. L. Stephen Buchanan, DDS, of any objection patient may have to the use of the above-described products or companies with which Dr. Buchanan has a financial relationship. If so, please list in the space provided:

_____
_____
_____

Acknowledged and understood this _____ day of _____

_____ Patient's Signature

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Office Financial Policy

1. Payment Policy

   Payment is due upon arrival in our office before treatment is started. In addition to our normal cash or check services, we do offer Visa, MasterCard or Discover

2. Dental Insurance

   The office of L. Stephen Buchanan, DDS is not contracted with any one insurance, our office will bill your insurance as a courtesy. Payment is due upon arrival in our office before treatment is started.

3. Cancellation Policy

   Because your appointment time is reserved only for you, 48 hours is required in the event you need to cancel your appointment. Cancellations made with less than 48 hours notice will result in a $175 per hour cancellation fee per hour.(No cancellations will be accepted after 4:45pm on Fridays and throughout the weekend.)

I agree to financial policy:

Print name_____

Signature_____ Date_____

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LIVE PATIENT DEMONSTRATION CONSENT FORM

For Patients Participating in a Live Demonstration for the purposes of Dental Continuing Education: I agree and hereby consent to Dr. Buchanan performing dental work for and upon me as part of a "live patient" demonstration during a continuing dental education training course. I understand Dr. Buchanan will be the sole clinician performing the demonstration, and that course participants will be observing the procedure in its entirety. I further state that the nature and extent of the techniques, procedures, and treatment I will be receiving have been explained to me. I have been informed about the potential risks of using the techniques that will be applied as part of the demonstration.

I have been informed of alternative procedures that are available to me, and my options with respect to each such available alternative procedure. I am aware that one such option that is available to me is that I receive no treatment at all. Having considered the options and alternative procedures available to me, I have agreed to the specific procedure to be completed by Dr. Buchanan during this demonstration. I am aware that I have the absolute right to discontinue treatment at any time.

PLEASE SIGN IN THE SPACE BELOW UNLESS YOU HAVE QUESTIONS FOR THE DOCTOR.

If there is anything you do not understand about the endodontic procedure, or any statements in this form, or if you still have any questions after reading this form, please discuss them with the doctor before signing below. Thank you.

Signature _____ Date _____

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Authorization for Disclosure of Patient Records

I hereby **authorize Dr. Stephen Buchanan DDS** to release my records to

_____ .

_____ _____
Print Patient Name Patient Signature

_____

Date

Authorization for Communication Via Text Message and or email:

I hereby **authorize Dr. Stephen Buchanan DDS** to Contact me via **text message at**:

_(____)_____---_____ , and or Email at:_____

_____ _____
Print Patient Name Patient Signature

_____

Date

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