Michael W. Hembrough, D.D.S., M.S.
Jack D. Kemper, D.M.D.

Dental History

Reason for Today's Visit (please describe on the line below)

_____

(Please check all of the following that apply)

Location of Symptoms

__ Upper Right
__ Lower Right
__ Upper Left
__ Lower Left
__ Upper Front Tooth/Teeth
__ Lower Front Tooth/Teeth

Symptoms Caused By

__ Heat
__ Cold
__ Biting
__ Chewing

Type of Symptoms

__ Constant
__ Occasional
__ Momentary
__ Lingering
__ Radiating
__ Sharp
__ Dull
__ Throbbing
__ Spontaneous

_____

Please PRINT name

Michael W. Hembrough, D.D.S., M.S.
Jack D. Kemper, D.M.D.

MEDICAL HISTORY

The following questions are for our record only and will be considered confidential information.

Do you have or have you had any of the following:

Please circle the correct response and answer all questions.

Yes No..... Latex Allergy?
Yes No..... Rheumatic Fever?
Yes No..... Hypertension (High blood pressure)?
Yes No..... Heart attack, irregular heart rate, damaged heart valves, or angina?
Yes No..... Stroke?
Yes No..... Heart murmur?
Yes No..... Chest pain or shortness of breath on exertion?
Yes No..... Swollen ankles?
Yes No..... Blood disorders such as anemia or hemophilia?
Yes No..... Frequent nosebleeds, increased bruising or bleeding?
Yes No..... Asthma, Tuberculosis or hay fever?
Yes No..... Hives or a skin rash?
Yes No..... Have you ever had a reaction to any drugs?
If yes, which drug? _____
Yes No..... Do you have any allergies?
Yes No..... Are you immunosuppressed (subject to frequent infections)?
Yes No..... Have you been told you have AIDS, ARC or an HIV positive test?
Yes No..... Ulcers, stomach or intestinal problems?
Yes No..... Hepatitis (jaundice) or liver disease?
Yes No..... Diabetes (high blood sugar)?
Yes No..... Tendency to faint, have convulsions, seizures or epilepsy?
Yes No..... Are you taking ANY medications now?
If yes, please list the prescription drugs and non-prescription drugs

_____

_____

Yes No..... Have you taken any steroids in the last six months?
Yes No..... Do you get frequent or severe headaches?
Yes No..... Have you ever had eye, ear, nose or sinus problems?
Yes No..... Do you have difficulty swallowing?

GENERAL

Yes No..... Are you in good health?
Yes No..... Have you ever had Arthritis (painful, swollen joints)?
Yes No..... Have you ever had an artificial joint or a pacemaker placed or replaced?
Yes No..... Cancer, chemotherapy or radiation therapy?
Yes No..... Venereal disease (syphilis, gonorrhea, herpes or other)?
Yes No..... Are you being treated by a physician now?
If yes, for what condition?_____
Yes No..... Been hospitalized, had major surgery or been seriously hurt?
Yes No..... Are you pregnant?
Yes No..... Does your jaw click, pop or hurt when you chew?
Yes No..... Does your physician require you to take an antibiotic before all dental work?

I certify that to the best of my knowledge the above information is complete and accurate. I understand that treatment is no guarantee of success and that factors such as infection, pain, tooth fracture and other complications may affect the outcome of the treatment. I also understand that I am to return to my dentist for a more permanent restoration at the completion of the endodontic treatment.

Patient's signature _____ Date _____

PATIENT INFORMATION

Name _____ Date _____

Address _____ Home Phone _____

City/State/Zip _____ Cell Phone _____

Birthdate _____ Social Security # _____

Employer _____ Work Phone _____ Ext. _____

❑ Male ❑ Female ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

General Dentist _____ Physician _____

Emergency Contact _____ Phone _____

RESPONSIBLE PARTY

Who is responsible for the account? Name _____ Relationship _____

Address (if different than patients) _____ Home Phone _____

City/State/Zip _____ Cell Phone _____

Birthdate _____ Social Security # _____

Employer _____ Work Phone _____ Ext. _____

DENTAL INSURANCE INFORMATION

Primary

Name of Insured _____

Relationship to patient _____
(if different than above)

Insured's Birthdate _____

Identification # _____

Employer _____

Insurance Company _____

Group # _____

Secondary

Name of Insured _____

Relationship to patient _____
(if different than above)

Insured's Birthdate _____

Identification # _____

Employer _____

Insurance Company _____

Group # _____

AUTHORIZATION AND RELEASE

I consent to the dentist's disclosures of my information, which he deems are necessary in connection with my treatment.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services, and that the insurance payment estimates I receive are only estimates and not a guarantee of payment.

I agree to pay the estimated co-pay at the time of service. Any remaining balance due after insurance pays their portion is my responsibility and is due within 30 days of receipt.

I agree to pay a service charge reflecting an annual rate of 7% that will be added monthly to any unpaid balance that is not paid within 30 days.

I agree that in the case of default on payment of this account, I will pay all collection costs and reasonable attorney fees incurred in attempting to collect this and any future outstanding account balances.

I realize that failure to keep this account current may result in our office being unable to provide additional dental services.

By signing below you affirm that the above information is accurate, agree to our payment terms, and consent to our disclosures of your information that our office deems necessary in order to provide proper treatment.

X _____

Signature of patient or parent if minor Date

Notice of Privacy Practices
Root Canal Specialists North, PLLC

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a revised Notice if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not described within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication -This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI - This means you may submit a written request to inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. In most cases, we will provide requested copies within 30 days.

You have the right to request a restriction of your PHI -This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf. has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - You may request a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights or would like to submit a written request, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

(616) 361-6609

We will not retaliate against you for filing a complaint.

Effective Date 1/25/24 Publication Date 1/25/24

Michael W. Hembrough, D.D.S., M.S.
Jack D. Kemper, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ (Print Name), understand that there is a copy of this offices Privacy Practices posted in the office and I can request a printed copy if needed.

_____

(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.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Please Specify)

_____

_____

(Office Staff Signature) (Date)

Michael W. Hembrough, D.D.S., M.S.
Jack D. Kemper, D.M.D.

ENDODONTIC CONSENT AND INFORMATION FORM

Root Canal Therapy, Endodontic Surgery, Anesthetics and Medications

We would like to inform you of the various procedures involved in endodontic therapy and have your consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which might otherwise 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 or 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 transient but, on 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; 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 fillings, crowns or porcelain veneers; 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), splits or fractures of the teeth.

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

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms, 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, consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I understand the doctor will examine me and proceed with treatment only after he explains what he will do. I have the right to refuse treatment after this examination. I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, I understand that it is still a biological procedure and cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction. Finally, I understand that upon completion of root canal therapy in this office, I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown, cap, jacket, onlay, or silver or resin filling.

PATIENT'S NAME (PLEASE PRINT) _____

SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated each year.

Patient Name: _____

SSN (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information: _____

_____

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays;
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

You have the right to receive a copy of signed authorizations upon request.

Patient Instructions for Form 7.31

Limited Patient Authorization for Disclosure of Protected Health Information

The Limited Patient Authorization will give our office the authority to provide the person or entity you designate on the form with access to your protected health information (PHI). The Limited Patient Authorization is limited to accessing only the information that you designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your health information to a person or entity that may be involved in your healthcare.

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Patient Name - Print your name.

Social Security Number and Date of Birth - This information is needed for identity verification and will be maintained in a confidential manner at all times.

Entity Requested to Release information - This simply identifies who is to provide the information.

Purpose of Request- To disclose your protected health information to an individual.

Who will be authorized to receive information – Enter the name, address and phone number of the individual or entity that you are designating to receive the disclosure.

Description of Information to be disclosed - The type and amount of health information that we disclose is determined by you. We can disclose or provide access to all of your health information, or it can be limited to a specific item.

Purpose of Disclosure - Regulations require that we identify the purpose for disclosing limited information. You also have the right to keep the purpose to yourself by selecting "Patient Request."

Expiration or Termination - This authorization will expire at the end of the calendar year in which it was signed unless you specify an earlier termination. The authorization must be renewed each year as a means of protecting your information by verifying your wish to continue the authorization for disclosure.

Right to Revoke or Terminate - You may revoke or terminate the authorization at any time by submitting written notice to our Privacy Manager.

Non-Conditioning Statement - This simply states that our practice does not place conditions for treatment on the use of the authorization.

Redisclosure Statement - We cannot be responsible for what the receiving entity does with your health information that we provide under this authorization. The redisclosure statement simply informs you of this situation.

Signature and Date - We will need your signature and date of the signature to make the authorization effective.

Copies - We will provide you with a copy of this signed authorization upon request.

