Avni Maru D.M.D, MSD Mark Barr D.D.S.

Welcome to our practice!
Specializing in gentle and excellent Endodontic care.

Please complete the following information so we may better serve your needs.
All information will remain confidential. Thank you.

Name _____ **Spouse** _____

Residence _____ **City** _____ **State** _____ **Zip** _____

Mobile # (_____) _____ **Home #** (_____) _____ **Work #** (_____) _____

Birthdate _____ **E-mail** _____

Employer _____ **Occupation** _____

Pharmacy Address and Phone #: _____

To whom may we give thanks for referring you to our office? _____

PAYMENT IN FULL IS EXPECTED AT THE TIME SERVICES ARE RENDERED. Although we cannot accept insurance as a form of payment, this office submits primary insurance claims as a courtesy to the patient. The insurance contract is between the patient and the employer/insurance company and thus any reimbursement will come directly from the insurance company. **Please present your ID and insurance card the day of your visit or email a copy of the front and back of the card to info@eob.life Note: we need the information below to be able to mail the claim.**

DENTAL INSURANCE INFORMATION

Insured's Name _____ **SSN #** _____-_____-_____ **DOB** _____

Relation to patient _____ **Employer** _____ **Occupation** _____

Insurance Company _____ **Group #** _____ **Member #** _____

Insurance Co. Address _____ **City** _____ **State** _____ **Zip** _____

Insurance Co. Phone (_____) _____

_____I understand although root canal therapy has a high degree of success, it is still a biological procedure, so success cannot be guaranteed. Occasionally, a tooth that has had root canal may require retreatment, surgery or even extraction.

_____I have been informed and understand there are certain inherent and potential risks in any treatment procedure. These including swelling, bruising, discomfort, infection and numbness of tongue or tingling of the lips and/or jaw from the delivery of local anesthetic.

_____Fractures of existing restorations, the tooth, and/or instruments used to perform treatment may occur. Additionally, variations in canal shape and size may complicate treatment and result in a perforation (hole) of the root or root canal filling.

_____I understand that only the root canal treatment is to be done at this office (endodontists are dental specialists uniquely trained to carefully and comfortably treat diseases of the root complex), and I also understand the permanent restoration (Filling, crown, post, core etc.) will be done by my general dentist following root canal therapy.

***Permission for Root Canal Treatment*: I consent to the performance of any dental procedure determined to be necessary in the opinion of the doctor. I agree to ask any questions so I will be clear as to what is necessary to correct the current condition. I understand my other options are no treatment or other dental consultations if desired.**

In the event this account should be placed with an outside agency for collection I agree to pay all agency fees, penalties, court costs and attorney fees incurred. I also agree to pay all penalties for returned checks. All information is true and complete.

Signature _____ **Date** _____

MEDICAL HISTORY

Please complete the following questions so we may thoroughly consider the status of your current health and relate its significance with a proper dental diagnosis and treatment. Complete confidentiality will be given to you.

Age _____ Weight _____ Are you prone to getting cold sores? Yes or No

[Y] [N] Do you have a *heart murmur, MVP, arteriovenous stent or shunt, artificial joint or hip, or any condition that requires a Pre-medication from a Medical Doctor or specialist prior to your dental appointments?* _____
If yes, which antibiotic do you take? _____

[Y] [N] Are you under the care of a physician for a current problem OR any negative change in health in the past year?
Please specify _____
Doctors name _____ and phone number: _____

[Y] [N] Have you ever had any allergic or adverse reactions to anesthetics, antibiotics, iodine, Latex or other medications? **Please list:** _____

[Y] [N] Have you been hospitalized within the past five years?
Reason_____

[Y] [N] Are you currently taking any medications?
List medications_____

[Y] [N] Are you on bisphosphonates (Fosamax, Boniva, Actonel, Reclast, Zometa, Didronel or Prolia) ? _____

[Y] [N] Have you received therapy for alcoholism or drug addiction?
When? _____

[Y] [N] Have you ever had abnormal bleeding from a previous injury, surgery or tooth removal? _____

[Y] [N] Have you ever received a blood transfusion?
Provide date and reason_____

[Y] [N] Have you ever had chemotherapy and/or radiation treatment for a tumor, growth or other condition? _____

[Y] [N] Have you ever been tested for HIV infection, ARC or AIDS?
Date_____ Result of test [ ] Positive [ ] Negative

[Y] [N] Tobacco Use: { } cigarettes { }pipe { }cigar { }snuff { }chew
How many packs per day _____ number of years_____. { } Quit – When? _____
[Y] [N] Alcohol Use: drinks per day_____ drinks per week_____

Do you have or have you had any of the following? (please circle yes or no)

[Y] [N] High Blood Pressure
[Y] [N] Heart Murmur or Prolapsed Valve (MVP)
[Y] [N] Congenital Heart Disease
[Y] [N] Cardiovascular Disease: Heart Attack, Stroke
[Y] [N] Prosthetic Heart Valve, Bypass Surgery-Date_____
[Y] [N] Rheumatic Fever or Rheumatic Heart Disease
[Y] [N] Joint Replacement Prosthesis (Hip, Knee, etc.)
[Y] [N] Arterial-Venous Shunts
[Y] [N] Diabetes
[Y] [N] Ulcerative Colitis
[Y] [N] Sinusitis
[Y] [N] Cholesterol
[Y] [N] Thyroid Problems
[Y] [N] Stomach or Duodenal Ulcer
[Y] [N] Lung or Breathing Difficulty
[Y] [N] Asthma Inhaler Use? Yes No
[Y] [N] Epilepsy
[Y] [N] Temporal Mandibular Joint Pain (TMJ)
[Y] [N] Psychiatric Treatment
[Y] [N] Cancer
[Y] [N] Blood Disorders
[Y] [N] Hepatitis A, B, C
[Y] [N] Jaundice, Liver Disease
[Y] [N] Pacemaker

WOMEN: Are you pregnant? Yes No Trimester: 1 2 3 Are you nursing? Yes No Do you take birth control pills? Yes No

If yes, be advised that if you take antibiotics, an alternative method of birth control in addition to your regular use of the pill must be used for the duration of your cycle. If the antibiotic therapy overlaps into the next cycle, then continue the alternate form of contraception for that cycle as well. It is a good idea, there is reference in Medicine that accidental pregnancies can occur, and antibiotic use has been partially implicated.

EMERGENCY INFORMATION

Emergency Contact Name _____ **Relation** _____

Mobile # (_____) _____ **Work #** (_____) _____

Signature _____ **Date** _____

AVNI M. MARU, D.M.D., MSD
MARK A. BARR, D.D.S.
2556 Apple Valley Rd, STE 150
Atlanta, Ga 30319
(404) 724-5776

NOTICE OF PRIVACY PRACTICES

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. The Health Insurance Portability and Accountability Act encompasses significant instructions and requirements regarding the control of personal health information. The prevailing sections of the act are commonly known as HIPPA "Privacy Rule". The rule mandates that numerous precautions be taken, and safeguards put in place to protect our patient's personal health information.

Uses and Disclosures of Health Information

Treatment: We may use your health information about your treatment or disclose it to a dentist or physician or other health care provider providing treatment to you.

Payment: We may disclose your health information to obtain payment for services we provide to you. We may disclose your health information to another health care provider or entity that is subject to the federal privacy rules for its payment activities.

Appointment Reminders: We may disclose your health information to provide you with appointment reminders (such as voicemail messages detailing necessary pre-operative instructions).

To Your Family or Friend: We may need to disclose your health information to a family member or friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure.

We must provide notice to each patient, and we must make a good faith attempt to obtain written acknowledgement of receipt of the notice from the patient or guardian. We must also have the notice in our office in a clear and prominent location where it is reasonable to expect patients seeking service from us to be able to read the notice. Whenever the notice is revised, we must make the notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the notice to each new patient at the time-of-service delivery and to any person requesting a notice.

By my signature, I acknowledge in the Notice of Privacy Practices that federal law requires Dr. Mark A. Barr, D.D.S., P.C. to provide all patients regarding our privacy practices.

Signature: _____ Date: _____

Print Name: _____