**R. David Pagan, D.M.D., P.C.**
**Mark Vagnetti D.D.S.**
**Patient Acquaintance Form**

**Patient Information – *Please print clearly***

**Patient** _____
First Name Initial Last Name Preferred Name

Mailing Address_____ City _____State _____ Zip_____

Physical Address_____ City _____State _____Zip_____

Home Phone_(___ ___)_____ Work Phone_(_____)_____ Sex - M F Marital Status - M D S W

Social Sec. # _____ Driver's Lic. #_____ D.O.B._____/_____/_____

**Responsible Person**_____
(if patient is a minor) First Name Initial Last Name

Home Phone_(_____)_____ Work Phone_(_____)_____ Sex - M F Marital Status - M D S W

Address_____ City_____ State_____ Zip_____

Social Sec. #_____ D.O.B._____/_____/_____Relationship to Patient_____

## DENTAL Insurance Information

**Primary**
**Insurance Company Name**_____ Phone_(_____)_____

Address_____ City_____ State_____ Zip_____

Employer Name_____ Ph. #_(_____)_____

Address _____ City _____State____ Zip_____

Employee/Subscriber Name _____ D.O.B._____/_____/_____

Social Sec. #_____ Driver's Lic. #_____

**Secondary**
**Insurance Company Name**_____ Phone_(_____)_____

Address_____ City_____ State_____ Zip_____

Employer Name_____ Ph. #_(_____)_____

Address _____ City _____State____ Zip_____

Employee/Subscriber Name _____ D.O.B._____/_____/_____

Social Sec. #_____ Driver's Lic. #_____

## Referring Dentist _____
First Name Last Name
Office Address_____Ph. #_(_____)_____

******** THE FOLLOWING QUESTIONS WILL BE CONSIDERED CONFIDENTIAL ********

**Patient** _____
First Name Initial Last Name Preferred Name

1. Are you currently under a doctor's care for any serious illness? ……..…….. ___Yes ___No

If yes, give details._____

_____

2. Are you taking any prescription drugs or other medications? ……. ___Yes __No

If yes, what? _____

_____

3. Are you allergic to any drugs or medicines? ……. ___Yes ___No

If yes, what? _____

_____

4. Are you pregnant? ..... ___Yes ___No

If yes, due date: _____/_____/_____

5. Do you have any other health problems I should know about? …… ___Yes ___No

If yes, explain - _____

_____

6. Are you allergic to LATEX?.....____Yes ___No

7. Do you need to Pre Med before any dental procedures are done?.....____Yes ___No

If yes, explain-_____

_____

**PAYMENT POLICY**

**PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING!!**

**Patient** _____
First Name Initial Last Name

We are pleased to welcome you to our office. New patients are always appreciated. Our practice has grown as a result of its excellent relationship with our referring dentists and patients. As our patient, please feel free to ask any questions or express any concerns that you may have to Dr. Pagan or our staff.

We have established the following payment policy due to the delay of payment from insurance companies and also the lack of patient understanding for uncovered services within the individual's insurance policy. It is your responsibility to understand how your insurance policy pays for services rendered.

**IF YOU DO NOT HAVE INSURANCE …** Full payment is due at check-in prior to being seen by Dr. Pagan.

**IF YOU HAVE INSURANCE ...and** we are preferred providers with the insurance carrier, then you are expected to pay your **percentage** at check-in prior to being seen by Dr. Pagan. Your percentage is due regardless of whether you have both a primary and secondary insurance carrier. However, if your maximum benefits have been met for the year, you will be required to pay in full. The BlueCross BlueShield Federal Employee Program **does not** pay any benefits for root canals and those subscribers will be responsible for 100% of the procedure fee. Those patients with **Group Dental Services of MD**, **Inc**. are expected to pay co-pays for services, along with the required referrals submitted by the general dentist for any of the services prior to being seen by Dr. Pagan. **INSURANCES WITH HMO, DHMO, OR MEDICADE IS NOT ACCEPTED**.

**WE ARE NOT PREFERRED PROVIDERS WITH METLIFE OR ANTHEM**
**IF YOU HAVE INSURANCE WITH ANOTHER CARRIER ...** You will be expected to pay **100%** of our procedure fee at time service is rendered. As a courtesy, we will submit your insurance claim for you (primary only). This is done so you will be reimbursed directly from the Insurance Co.

**IF YOU ARE COVERED BY DISCOUNT INSURANCE ...** Your discounted fee is due at check-in prior to being seen by Dr. Pagan. In most cases, claims are not submitted for discounted dental policies in which we participate.

**ATTENTION ALL INSURANCE PATIENTS**

The amount of coverage paid by your insurance company is based on your insurance company's "usual and customary" fee schedule. Their fee schedule is normally *less* than our "actual" charges which we have no control over. Lower payment is a direct result of the plan selected by the subscriber's employer. If we are not preferred providers with your insurance company, you are responsible for the remaining balance after your insurance has paid its portion. This is calculated based on your maximum benefits available and on their "usual and customary" fee schedule.

In addition, the patient or responsible party (parent or guardian) is fully responsible for the total payment of services performed in this office. This includes any amounts not covered by health or dental insurance or prepayment program that the patient or responsible party may have. All balances are to be paid in full within 30 days of treatment date or, if applicable, after your insurance company pays. Balances over thirty (30) days will be subject to a 1.00% monthly interest charge (minimum charge of $1.00). If the account is turned over for legal collection, the patient or responsible party will be liable for all costs of collection including interest, court costs and attorney's fees. If you have any questions, please do not hesitate to ask the staff or Dr. Pagan.

_____ _____
Patient or Responsible Party Signature Date

Relationship to Patient_____

# ENDODONTIC CONSENT INFORMATION FORM

We want to inform our patients about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed to save a tooth which might otherwise need to be removed. The alternatives to endodontic therapy include no treatment, waiting for more definite development of the symptoms, and tooth extraction. Risks involved in these choices might include pain, infections, swelling and tooth loss.

Endodontics or root canal therapy is cleaning, shaping, disinfecting and filling the space (canal) inside the root of the tooth. A treated tooth usually functions normally and is a pulpless tooth, not a dead tooth. Treatment will require one or more visits depending upon the condition of the tooth. Almost always a local anesthetic will be needed to anesthetize (numb) your tooth. A minimal number of x-rays will be taken as indicated by the needs of treatment. Please be advised of the following:

1. The root canal fee will vary depending on the tooth being treated and the complexity of the case. Some patients need more than one procedure which may incur additional charges.

2. As a rule, 90% of routine cases are successful. Endodontics, as with any branch of medicine or dentistry, is not an exact science, thus no guarantee of treatment success can be given or implied. If the original treatment is not successful, it may be retreated, a surgical procedure may be required, or the tooth may need to be removed.

3. Endodontic therapy started in other offices or retreatment cases may have a different outcome than expected under optimal conditions.

4. **After root canal therapy the treated tooth must be restored (crowned) or failure of the root canal procedure is likely. Please contact your dentist soon after treatment to make an appointment to have your tooth restored.** Most teeth will require a crown so do not chew hard foods on the tooth until then. Otherwise <u>you</u> may run the risk of breaking or splitting the tooth which would then require extraction.

5. <u>Possible unavoidable complications of endodontic therapy include, but are not limited to</u>: Swelling, soreness, muscle spasm, fracture of the crown or root of the tooth, separation of root canal instruments during treatment, blocked canals due to filling or prior treatment, natural calcification, severely curved roots, root resorption, perforation of the root especially in cases of severe calcification, damage to existing/crowns or bridges, adverse reactions to anesthetics and medications administered and prescribed for treatment. During treatment complications may be discovered which make treatment impossible or which may require dental surgery.

I fully/completely understand the above statements and hereby give my consent to the performance of endodontic treatment. I further give my consent for the administration of medications, anesthetics, and services deemed necessary to treat my endodontic problem, fully understanding the risks involved. I hereby authorize and request you to release to my dentist and/or insurance companies my complete dental records concerning the treatment in this office.

_____ _____

Patient or Responsible Party Signature Date

_____

Relationship to Patient