Dr. Simpson and his staff Welcome you to Buckeye Endodontics

If you have brought a referral form, please turn it in with this paperwork.

PATIENT INFORMATION:

LEGAL Name:_____Date of Birth_____ SS#_____

Address:_____City_____State_____Zip_____

Preferred Contact Phone # _____ Email_____

Who's your General Dentist _____Who referred you to our office?_____

Emergency Contact Name:_____Phone #_____ Relationship_____

IF THE PATIENT IS A **MINOR**- Who is the legal guardian/parent?

Name of Parent/guardian:_____ Address:_____

City_____State_____Zip_____Contact Phone # (_____)_____

***Dental Insurance information: We will already have this on file, before your appointment.**

POLICIES OF BUCKEYE ENDODONTICS: PLEASE READ OVER POLICIES BELOW

- **Appointments: There is a $50.00 fee for a less than 24 hr notice of cancellation or rescheduling. If you do not show up for your appointment, there is also a fee.** If you are more than 15 minutes late, we may have to reschedule you. The fee for a missed appointment for multiple teeth or a Halcion appointment will be increased.
- **The patient who is appointed is the sole person in the room during treatment.** Parents will attend their MINOR child's eval-only appointment to give time for questions regarding their child's upcoming treatment. Small children can not be left alone in the office; we can no longer have anyone other than the patient in the treatment room for safety and liability reasons. Translators will be permitted in the office during evaluation appointments only.
- **Privacy Policy:** Our privacy policy (HIPAA) is available at the check-in desk. If you do not want your private information shared with a spouse, or parent, please inform us in writing.
- **Financial: Co-pays are due at time of treatment.** The account balance, whether the insurance denies coverage or not is the responsibility of the patient or guardian. If a balance goes 30 days unpaid an interest charge will be added & after 60 days your account will be sent to pre-collections. CareCredit is accepted at this office. **We no longer take personal checks.**
- If you had an evaluation at your general dentist in the last 6 months, and have dental insurance,you may owe for your evaluation at this specialty office, due to insurance frequency limitations.
- By signing below, I acknowledge that I have read the above policies. I am aware I will have to follow up with my general dentist 2-4 weeks after root canal treatment. I agree to release my treatment information to my insurance companies, my general dentist, and any relatives who may call to ask about my treatment at this office. I am aware Buckeye Endodontics will communicate with my general dentist by email or mail to inform them of any treatment I may have done today or in the future. I give my consent to Dr. Gregory Simpson to examine, x-ray, and treat my Endodontic condition. Dr. Simpson strives to keep all crowns intact during treatment. Any crowns could need to be replaced due to unforeseen circumstances. There can be chipping and cracking of any crown. I understand there are risks with having endodontic treatment.

SIGNATURE OF PATIENT or GUARDIAN OF PATIENT_____Date_____

****PLEASE FILL OUT THE BACK SIDE OF THIS SHEET --->>> ----->>>>>FLIP OVER ->**