Welcome to Pinnacle Endodontics, Periodontics and Implants

Embree A. Dowling, D.M.D. * Patti C. Dowling, D.M.D. * Iveliss Rodriguez, D.M.D. * Jesse Rosario, D.M.D.

Patient Information:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name__________________M.I. ___Last Name________________________

☐ Male ☐ Female ☐ Prefer not to disclose

Birth Date___________ Age_____ Social Sec #_________________E-mail_______________________________

Street Address___________________________________City___________________ State______Zip ________

Cell (_____)____________________ Home (______)____________________ Work (______)_____________

Employer____ Referred by_______________________________

Dentist Name _________________________________ Orthodontist Name _____________________________

Minor accompanying parent/guardian information: ☐ Father ☐ Mother ☐ Other (relation) _______________

First Name_________________ Last Name______________________ SS# _______________ DOB___________

Cell (_____)_______________ Home (______)____________________ Work (______)___________________

Street ________________________________City_________________________ State_______ Zip___________

HIPPA ACKNOWLEDGEMENT I acknowledge receipt of a copy of the Pinnacle Endodontics, Periodontics and Implants Notice of Privacy Practices

____ ____________________________________ __________

Signature of Patient (Parent/Guardian if Minor) Name Date

AUTHORIZE THE RELEASE OF MY MEDICAL AND FINANCIAL RECORDS TO THE FOLLOWING:

Name____Relationship____________________

Name____Relationship_____________________

Pharmacy____

Name Address Phone Number

Primary Dental Insurance

__________________ __________ ___________

Subscriber Name Relation Date of Birth

Group# _________ Employer _________________

Insurance Co Name_________________________

Telephone# (______)________________________

SS#_________________ ID #_________________

Secondary Dental Insurance

__________________ __________ ___________

Subscriber Name Relation Date of Birth

Group# _________ Employer _________________

Insurance Co Name_________________________

Telephone# (______)________________________

SS#_________________ ID #_________________

PINNACLE

ENDODONTICS · PERIODONTICS · IMPLANTS

MEDICAL HISTORY

PATIENT NAME ______________________ Birth Date ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______________________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ______________________

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______________________

Comments: ______________________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ______________

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FINANCIAL POLICY/CANCELATION POLICY

- All services rendered are subject to review until paid by insurance and therefore the amount we collect for your co-pay is on an **ESTIMATE**. Once the claims are paid and adjustments if any are made the balance remaining is your responsibility.
- We will submit a predetermination of benefits to your insurance, this can delay surgery 4-8 weeks and is still not a guarantee of payment.
- The patient, or legal guardian for minors, is responsible for all amounts not covered by the insurance.
- If after 90 days there is still a balance on the account, the patient or legal guardian is responsible for the balance, all rebilling charges, interest charges, collection costs and attorney fees.
- **If you choose to not provide us with your social security number (accompanying legal guardian if patient is a minor) then we will collect up front for all procedures and file for your insurance to reimburse you.**
- Full payment is due at the time service.
- If you do not provide at least 24 hours notice when canceling or rescheduling a surgery appointment, you must pre-pay your copay prior to rescheduling the appointment.
- **THE INDIVIDUAL PAYING FOR THE SERVICES RENDERED MUST BE PRESENT IN OUR OFFICE AT THE TIME OF PAYMENT.**
- Patient payments can be made by cash, credit card or care credit.

I have read and understand and agree to this financial policy.

______________________________	______________________________
Signature of patient/Responsible Party	**Date**
______________________________	______________________________
Name of Patient	**Name of Responsible Party (if patient Is a minor)**

Dr. E. Alan Dowling, DMD
Periodontist
Dr. Patti C. Dowling, DMD
Endodontist
Dr. Jesse Rosario, DMD
Endodontist
Dr. Iveliss Rodriguez, DMD
Periodontist

6150 Metrowest Blvd.
Suite 301
Orlando, FL 32835

(407) 532-9856
www.pinnacle-epi.com

ATTENTION

I understand that a CBCT scan might be taken at my visit today as part of my assessment for periodontal/endodontic treatment. I acknowledge that my dental insurance offers **NO** coverage for the scan and accept the fee incurred ranging from $175 to $275.

____
Print name

______________________________ ______________
Signature Date

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Opioid Addiction Prevention Act 2017 (CS/CS HB21)

Prescription opioids can be used to help relieve moderate to severe pain when recovering from surgery. They should be used for breakthrough pain as acetaminophen and NSAIDS are the first choice. Due to the opioid epidemic that we are facing, the Opioid Addiction Prevention Act was signed into law in 2017 and practitioners are obliged to follow these guidelines:

- Prescribers will consult the state Prescription Monitoring Program (PDMP) before prescribing you opioids.
- No prescription for opioids is allowed if you have another recent prescription, if you have been prescribed opioids by 4 or more doctors or if opioids have been filled in multiple pharmacies. In these situations an alternative medication will be prescribed.
- Prescriptions are limited to a 3-day supply. If medicine is lost, stolen or used up sooner than indicated your medication will not be replaced.
- IF A REFILL IS REQUIRED, CONTACT YOUR DOCTOR DURING NORMAL BUSINESS HOURS. ANY REFILLS WILL BE READY THE NEXT BUSINESS DAY. REFILLS WILL NOT BE PROVIDED ON NIGHTS, HOLIDAYS OR WEEKENDS.

Prior to taking opioids you must:

- Report any and all medications and health issues to your prescribing doctors.
- Report any addiction problem to your doctor.
- Do not take other medications or prescribed opioids from other doctors without informing them.
- Never use another person's prescription opioids or share, sell or trade your own ordered.
- Always take the prescribed opioid as directed and never take more than your doctor ordered.
- Understand that opioids have side effects such as nausea, vomiting, dry mouth, sleepiness, dizziness, confusion, depression, itching, sweating, constipation and addiction. An overdose can cause slowed breathing, which could be fatal.

My signature below acknowledges I have read and understand the information provided to me and my questions have been answered.

Patient Name______________________________________ Date___________________

Signature(Parent if patient is a minor):____

Patient COVID-19 Advisory and Acknowledgement

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have presented to the office today for a dental condition which can be treated at this time but could be postponed if needed, until the current COVID-19 risk period abates. Please be advised of the following:

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please ne truthful and candid in your answers.

Have you received the COVID-19 vaccine? Yes - Dose 1 __ Dose 2 ___ / No
Do you have any shortness of breath? Yes / No
Do you have a runny nose? Yes / No
Do you have a sore throat? Yes / No

Within the last 21 days have your traveled to any foreign country or within the U.S.? If so, when and where did you travel?

____

_______________________________________ __________

Patient/ Responsible Party (Print and Sign Name) Date