Welcome

Advanced Dentistry & Dental Implant Center

We are excited to have the opportunity to serve you. It is our ambition to create a practice based on a reputation for convenience, cooperative efforts and a mutual concern for your well being, while providing clinically competent care. Our goal is to provide services, with regard to both care and skill, that remains at the heart of our philosophy.

Our mission is to serve our patients in a courteous, professional and kind manner. We will strive to let each patient know they are valued. We will attempt to provide technology enhanced healthcare with minimum discomfort. Thank you for coming to our practice.

Russell Kiser II, D.D.S., M.S., EMT-P

Today's Date: __________

Referring Dentist's Name: _______________

ABOUT YOU:

E-mail: ____

Name: ____ Preferred Name: ______________________

Last *First* *MI* *Mr/Mrs/.Ms./Dr.* *Nickname*

Home Address: ____

Street *City* *State* *Zip*

Phone Contacts: _________________ _____________________ _______ ______________________

Home *Work* *Ext.* *Cell*

Date of Birth: ___/___/___ Age: _____ SS#: ______-______-______ ___ Male ___ Female

Employer: ___________________________ Address: ______________________________________

Street *City*

ABOUT YOUR SPOUSE OR PARENT:

Name: ____ Date of Birth: ____/_____/____

Employer: ___________________________SS#____________________ Work Phone#: _____________

DENTAL INSURANCE:

Primary Dental Insurance

Insured's Name: ___________________________________Insurance Company______________________

ID/SS#: ______-______-______ Address: _____________________________Phone#__________________

Insured's Relation to Patient: ______________________________ Date of Birth: ________________________

Do you have secondary Insurance? Yes _____ No _____ If yes:

Secondary Dental Insurance

Insured's Name: ___________________________________Insurance Company______________________

ID/SS#: ______-______-______ Address: _____________________________Phone#__________________

Relation to Patient: ______________ Employer:______________________ Date of Birth: ___________________

______________________________ I hereby authorize insurance payment directly to the above named dentist.

(Patient or Guardian signature)

Personal Data
Property of Advanced Dentistry & Dental Implant Center

Patient Name ______________________________________ **Date** ____________

Date of Birth ______________________

Biographical Data(age/race/gender)____

Chief Complaint (Why are you here?) ____

____

Present Illness (History of your problem)____

____

MEDICAL HISTORY

1. Do you have or have you had any of the following diseases?

   a. rheumatic fever or rheumatic heart disease......................... YES NO
   b. heart murmur or mitral valve prolapse............................... YES NO
   c. heart disease/heart attack.. YES NO
   d. artificial heart valve... YES NO
   e. irregular heart beat.. YES NO
   f. pacemaker... YES NO
   g. high blood pressure.. YES NO
   h. chest pains or angina.. YES NO
   i. stroke.. YES NO
   j. artificial joint.. YES NO
   k. hepatitis/liver disease... YES NO
   l. tuberculosis (TB)... YES NO
   m. thyroid trouble.. YES NO
   n. kidney disease.. YES NO
   o. diabetes (sugar).. YES NO
   p. asthma... YES NO
   q. HIV or other immunosuppressive disease......................... YES NO
   r. radiation or cancer therapy.. YES NO

2. Do you have or have or have you had any disease, condition or problem not listed here……………………………….. YES NO

3. Have you ever been hospitalized, if so, why? .... YES NO

4. Have you had excessive or prolonged bleeding requiring special treatment?......YES NO

5. Have you had an allergic reaction to any drugs or medications?
   (Circle all that apply: penicillin; codeine; aspirin; sulfites; sulfa; latex; anesthetics; other)... YES NO

6. Are you currently under the care of a physician (M.D., D.O.)?............. YES NO
   When were you last seen by a physician?______________
   Name of Physician________________________________
   Street Address____________________________________
   City, State, and Zip Code___________________________
   Phone________________________

7. Are you pregnant or nursing? Estimated Date of Delivery.................... YES NO

8. Have you had any trouble associated with previous dental treatment?.... YES NO

9. Do you have any lumps or sores in your mouth now?............................ YES NO

10. Do you smoke or use smokeless tobacco?.. YES NO

11. How often do you have dental check ups?_______ Date of last Exam__________

12. Are you currently taking any drugs or medications
(such as antibiotics, heart medicine, birth control pills?)..........................YES NO

CURRENT MEDICATIONS

Trade Name	Generic Name	Dose/Frequency	Reason

IT IS YOUR RESPONSIBILITY TO PROVIDE A LISTING OF YOUR MEDICATIONS

I have reviewed the information I have provided, and to the best of my knowledge it is correct and complete.

Patient/Guardian Signature: ____________________________ **Date**: _____________

SUMMARY OF PATIENT'S MEDICAL STATUS:____

____

____

(DOCTOR-USE ONLY):

MEDICAL RISK ASSESSMENT (check one)

□ ASA I (healthy individual)
□ ASA II (mild systemic disease)
□ ASA III (severe disease but not incapacitating)
□ ASA IV (incapacitating systemic disease) (constant threat to life)

MEDICAL CONSULTATION REQUIRED

□ No (healthy and/or stabilized disease)
□ Yes (ASA III or IV; cardiac murmur; vague hx; recent major disease; recent diagnosis/operation; uncontrolled disease; blood pressure; etc.)

Does the Chief complaint require emergency treatment? .... NO YES

Doctor Signature: __________________________________ **Date:** _______________

Advanced Dentistry & Dental ~~Implant Center~~

Russell Kiser II, D.D.S., M.S., EMT-P

General Information **Office Financial Policy**

Thank you for choosing Dr. Kiser as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

All patients must complete our Health History and Insurance Information Form before seeing the doctor.

If you do not have dental insurance, full payment is due at the time of service. If you have dental insurance, we will estimate the insurance portion and you are to pay the amount not covered by your insurance at the time of service. The insurance *estimate* is not a guarantee of payment, and **you are responsible for any amount not paid by your insurance.**

As a courtesy of this office, most dental claims are filed electronically daily. This type of filing accelerates the claim processing for a most expedient reimbursement of benefit. Dental claims for major treatment are filed manually with supporting documents (i.e. x-ray, narrative, etc.).

Patient Payment/Financing Options

Option 1) **Cash/Check**

Option 2) **Visa/MasterCard/Discover/Amex/Bank Debit**

Option 3) **Care Credit or Springstone Financial**
*Please arrange your finance option **prior** to your appointment, by securing on-line at carecredit.com or springstoneplan.com

- Same as cash, if paid in full, within specific time limit / minimum monthly payment is required.

Balance of $1 - $500...................90 Days Same as Cash
Balance of $501 - $999...............Six Months Same as Cash
Balances Greater than $1000......12 Months Same as Cash

- Revolving charge, if not paid in full within same as cash requirements. (Monthly interest rate varies--see brochure)
- No penalty for early payoff
- Establish a line of credit for future treatment

Thank you for reading and understanding our General Information form. Patients who do not provide at least 48 hours notice for a treatment appointment / 24 hours for an exam or cleaning appointment and are a ‘no show’ or cancellation may be assessed a $150.00 charge (because of the lengthy loss of time required to honor *your* appointment). If you have questions, please ask prior to your treatment.

I understand and agree to the terms as outlined above:

X____ **Date**:_____________
Signature of Patient or Responsible Party

Consent Form

Potential Risks or Complications Including but not limited to:

1. Allergic reactions or side effects to materials or medications administered during or prescribed after the procedure is a rare, but potential risk.
2. Infection or Inflammation (Flare-up) is a potential risk from having root canal treatment, with or without discomfort/pain.
3. On rare occasion, nerve injury is a potential risk from having root canal treatment or surgery. (usually reversible)
4. Root canal treatment may be judged as "difficult" requiring further treatment or a change in planning. Sometimes unpremeditated.
5. Root canal treatment can be unsuccessful in a small number of certain instances requiring retreatment or surgical treatment.
6. Root canal treatment may be infeasible in certain situations that may require the tooth to be extracted (and maybe grafted); this may be discovered during examination, treatment, or possibly after treatment. **We want to help you save your tooth**, but if situations present that render a diminished prognosis we recognize that in all practicality it is best to recommended removal with hopes for replacement by implantation if you are a suitable candidate or by other means.
7. Procedural complications happen occasionally and are a possibility that may require further treatment.
An example, but not all-inclusive: A separated instrument (an instrument that comes apart in the canal) is a potential risk. Sometimes it is not feasible to remove the instrument non-surgically and this may require that it be incorporated and left in the filling of the root canal or treated surgically. It would be unusual and rare that this would be a problem that we could not resolve for you.
8. On rare occasion, if you have a crown (cap) on your tooth, it is possible that the crown could be injured beyond repair necessitating that a new restoration be made and be at your financial responsibility. Examples include: the porcelain fracturing off of the crown during root canal treatment that could not be repaired or significant tooth decay underneath the crown that cannot be detected by an x-ray, but is discovered during root canal treatment and/or the crown comes off because of lack of adequate tooth structure.
9. Other unforeseen risks are possible from having root canal treatment that may require the tooth to be extracted (removed). I understand that the following may be inherent or potential risks for the treatment I will receive:
   swelling; sensitivity; bleeding; pain; infection; numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; reactions to injections; changes in occlusion (biting); jaw muscle cramps and spasm; temporomandibular joint difficulty; loosening of teeth, crowns or bridges; referred pain to ear, neck and head; delayed healing; sinus perforations; treatment failure; complications resulting from the use of dental instruments (broken instruments-perforation of tooth, root, sinus), medications, anesthetics and injections; discoloration of the face; reactions to medications causing drowsiness and lack of coordination; and antibiotics may inhibit the effectiveness of birth control pills for 1-cycle (if prescribed by your dentist or us).
10. It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted. Eg. At times, natural teeth cannot be recommended to be salvaged and extraction or implant dentistry might be offered.
11. I have been given the opportunity to question the doctor concerning the nature of treatment, the inherent risks of the treatment, and the alternatives to this treatment.
12. This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment and I was provided with an opportunity to talk with the doctor.
13. I have been informed of possible alternative methods of treatment including no treatment at all.
14. I have informed the doctor about all of my medical conditions, all medications/pills/drugs that I am taking, and all allergies (environmental and medications) that I know that I have. I understand it is my responsibility and burden to inform the doctor, at every visit, of any drug prescription changes/additions/deletions or over-the-counter or homeopathic drug changes/additions/deletions.
15. Often, apical surgery is combined with root canal therapy to enhance success rates. Although risks are extremely small, nerve impairment or injury could occur that could be temporary or permanent. Infection is a remote possibility, but always possible.

Post-treatment instructions

a. You may have discomfort after the procedure that typically may last for a day or two. Medications may be prescribed to alleviate your discomfort. Take the medication(s) as prescribed by your doctor and use caution because some pain medications may cause drowsiness or interact with other medications and should not be taken while working, driving, or other daily tasks that require you to be alert and oriented. If an infection is present or starts after treatment an antibiotic may be prescribed if indicated. If you smoke you need to tell the doctor so he can advise you on how to avoid problems that may occur or that do occur due to smoking with treatment.
b. You may need to contact the doctor after treatment and may do so on his cell phone if urgent or at work if available. I am available and will return your call at my earliest convenience provided you leave your name and phone number.

Signature Required

It is implied that this consent form shall serve as consent for future care if you return for a different problem later on. I have read and understand the consent form and the nature of the procedure. All of my questions were answered by the doctor and/or supporting employees. I give consent to provide treatment.

Patient's Signature:____ **Date:**_______________

Patient or person authorized to give consent for the patient

Doctor's Signature: ____ **Date:**_______________

HIPAA

Advanced Dentistry & Dental Implant Center
Russell Kiser II, D.D.S., M.S., EMT-P
1245 S. Trimble Road, Mansfield, Ohio 44907

HIPAA--CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name (please print): ____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities (including submitting your insurance claim), and healthcare operations (including correspondence with your primary and/or referring dentist or allied health care providers thereof).

Notice of Privacy Practices: You have the right to read our Notice of Privacy before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is on file in our business office. You are welcome to read it before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Melissa or Terri
Telephone: (419) 756-2880 Fax: (419) 775-8820
E-mail: russellkiserii@earthlink.net
Address: 1245 S. Trimble Road, Mansfield, Ohio 44907

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of the Consent will *not* affect any actions we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities (including submitting your insurance claim), and health care operations (including correspondence with your primary and/or referring dentist or other allied health care providers thereof).

Signature: ____ Date: ________________________

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: __________________________________ Relationship to Patient: ___________________

(You are entitled to a copy of this Consent after you sign it)

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____ Date _______________________

Surgical Consent: There is a strong possibility towards having surgical apicoectomy/possible retrofill and surgical exploration in conjunction with endodontic (root canal) therapy to maximize your chances towards having a broader definition of success (minimal to zero post-operative pain or problems...as opposed to success being defined as simply 'tooth retention', 'asymptomatic but lesion still present', or 'symptomatic but nothing on the x-ray shows up but you still hurt', or 'other problems'. Post operative tenderness or pain is a reality in the aftermath of receiving endodontic care that a majority of the time can be eliminated by minor endodontic surgery. I do not define success myopically as 'tooth retention but still the tooth hurts' or 'absence of pain' or 'absence of problems on an x-ray'. Because, we must not forget that many patients do indeed have post operative sensitivity, tenderness, discomfort, or pain even when the best of nonsurgical endodontic care is rendered. Also, sometimes the infection/abscess/lesion continues to stay present after therapy or continues to 'grow'. It has been my experience after serving thousands and thousands of patients that combining care (nonsurgical root canal treatment or retreatment with surgical endodontics) offers the highest chance for prognostic assessment intraoperatively and higher chance for a broader definition of success. Surgical exposure also allows for proper exploration to help to know if aborting endodontic care should occur so that other options can be pursued such as extraction or extraction/graft. Seeing inside the root canal anatomy and having a surgical anatomic bone, root, sinus, and nerve view indeed allows for problems to be diagnosed or managed more effectively. Uncommonly, some insurance companies will not pay even a substantially reduced surgical fee when root canal therapy and surgery are performed on the same visit. This may mean that the surgical component of care, done at time of root canal therapy, may not be billable to your insurance provider. It is not my intention to let issues go unexplored or unresolved and then have to bring you back and put you through a second procedure if you do not achieve 'success'. When you are here, perhaps sedated, we're likely going to render combined care---I want you to have the highest chance for success. Complications with a surgical approach, with minor intraoral surgery, are minimal and almost always resolve if complications do rarely present.

Patient or Legal Guardian: ________________________________

Photography/Video Waiver: I, ________________________________, allow Advanced Dentistry & Dental Implant Center (Dr. Russell Kiser or liaisons thereof) to take and use digital photos or movie clip(s) of the procedure for training, educational, or for respectable advertising purposes. Your identity will not be disclosed and all attempts will be made to hide most aspects of your face to the point of being unrecognizable by others.

Patient or Legal Guardian: ____________________________________

Our Strongest Attributes

- Caring, Professional Dental Care
- Honest, Listens, Gives Options
- Clean and Modern Clinical Environment
- Friendly, Well-Trained Staff
- Highly-Trained Doctor (Trained Specialist Providing Advanced & Family Dental Care). This means you won't have to be referred all over for your care!
- Gentle and Thorough Hygienists
- Courteous and Organized Front Desk
- Highly-Skilled Dental Assistants

Services Offered

- Family, Cosmetic & Implant Dentistry
- Life-Like Durable Ceramic Teeth Repairs with Revolutionary "LiDi Technique"
- Life-Like Durable Natural Looking Veneers, Crowns
- Custom Dentures, Immediate Dentures
- Extractions, Wisdom Teeth
- Teeth-in-a-Day Dental Implant Surgical Reconstructions (Revolutionary all on 4 or all on 3 Implantations)
- Implant Supported Dentures & Hybrids
- Trained Specialist in Root Canal Therapy (Endodontist)
- Safely sedating and providing care in one visit if desired