Timothy H. Mihle, D.D.S.

Patient Information: **Date:**__________________

Name:

____
Last First M Date of Birth SS#

Circle:

Married Widowed Single Minor Male Female

Address:____
Street Apt# City State Zip

Mailing Address:____
Street/P.O. Box Apt# City State Zip

Telephone____
Home Work Cell

E-Mail:____

If the patient is under 18 years of age:

Name of Parent bringing child to today's appointment:

____SS#____________________________

Mailing Address:____
Street/P.O. Box Apt# City State Zip

Telephone:____
Home Work Cell

Dental Insurance Information:

Primary Insured Member Employer____

Name___________________________SS#______________________Date of Birth_____________

Primary Dental Insurance Co.____
Name Group# Address Telephone

Secondary Insured Member Employer____

Name__________________________SS#______________________Date of Birth______________

Secondary Dental Insurance Co.____
Name Group # Address Telephone

PHARMACY NAME & PHONE NUMBER

____ __________________________

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weakened or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	**No**
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside of the US in the past 14 days? **If so, where? ______________________**	☐	☐

1870 YEARS 2020

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Name: ___________________ Date: ___________________

TIMOTHY H. MIHLE, D.D.S, P.L.L.C

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME: ______________________ DATE OF BIRTH: ______________

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 MEDICATIONS THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECIEVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	Y	N
1. ARE YOU IN GOOD HEALTH?	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM ______		
4. PHYSICIANS NAME ______		
ADDRESS ______		
PHONE NO. ______		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN?	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
PLEASE EXPLAIN ______		
7. ARE YOU TAKING ANY MEDICINE(S)? INCLUDING NON-PRESCRIPTION MEDICINE	☐	☐
IF YES, WHAT MEDICINE(S) ARE YOU TAKING? ______		
8. HAVE YOU HAD ANY ABNORMAL BLEEDING?	☐	☐
9. DO YOU BRUISE EASILY?	☐	☐
10 HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS?	☐	☐
12. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES?	☐	☐
13. DO YOU / HAVE YOU USED CONTROLLED SUBSTANCES?	☐	☐
14. ARE YOU PRESENTLY ON A "PAIN MANAGEMENT" PROGRAM?	☐	☐
WHO IS YOUR DOCTOR? ______		
15. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?	☐	☐
16. ARE YOU TAKING BLOOD THINNERS?	☐	☐

WOMEN ONLY:

	Y	N
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
ARE YOU NURSING?	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

	Y	N
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
*PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVE OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G. NICKEL, MERCURY, ETC.)	☐	☐
LATEX/RUBBER	☐	☐
OTHER (PLEASE LIST)	☐	☐

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

	Y	N
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK OR ANGINA	☐	☐
CHEST PAIN	☐	☐
LUNG/BREATHING PROBLEMS	☐	☐
PACEMAKER	☐	☐
* HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐
ASTHMA OR HAY FEVER	☐	☐
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
DATE: ______		
STOMACH ULCER	☐	☐
TUBERCULOSIS	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORE/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐
KIDNEY DISEASE	☐	☐

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ON THE REVERSE SIDE OF THIS PAGE? ☐ **YES** ☐ **NO**

PLEASE DESCRIBE IN DETAIL ______________________________

DO YOU WISH TO TALK TO THE DOCTOR PRIVATELY ABOUT ANY DENTAL PROBLEM ☐ **YES** ☐ **NO**

EMERGENCY CONTACT INFORMATION: NAME ______________________ TELEPHONE NO ______________

INFORMED CONSENT

This is my consent to the endodontic procedures indicated and any other procedures necessary or advisable as a corollary to the planned endodontic therapy performed. I agree to the use of local anesthesia, sedation and/or analgesia, depending on the judgment of the endodontist. Complications of root canal therapy and anesthesia may include swelling, discomfort, infection, bleeding, sinus involvement, and numbness or tingling of the upper lip, gum or tongue, which rarely is permanent.

I understand root canal therapy is a procedure to retain a tooth that may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure so it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

I ALSO UNDERSTAND THAT THE ROOT CANAL THERAPY IS TO BE PERFORMED AT THIS OFFICE. THE PERMANENT (OUTSIDE) RESTORATION (FILLING, INLAY, CROWN, ETC.) WILL BE PERFORMED BY MY GENERAL DENTIST.

I understand that medications for pain and sedation may cause drowsiness which may be increased by the use of alcohol or other drugs. I will avoid operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call a doctor immediately. I understand that it is my responsiblity to report any changes in my medical history.

I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY FOR THEM, IN FULL OR BEFORE COMPLETION, UNLESS SPECIFIC ARRANGEMENTS ARE MADE WITH THE OFFICE MANAGER IN ADVANCE.

ALL SIGNATURES MUST BE BY PARENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE.

SIGNATURE ______________________________ DATE ______________

REVIEWED BY ______________________________

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I understand that insurance is filed as a courtesy to me and is not a guarantee of payment. I also understand that it is not the policy of this office to enter into any dispute between myself and my insurance company. If my insurance company has not paid within 60 days, I will be billed and any balance remaining on my account will be my responsiblity.

SIGNED (PATIENT OR PARENT IF PATIENT IS A MINOR) ______________________________
DATE ______________

I HEREBY AUTHORIZE INSURANCE PAYMENT DIRECTLY TO: Timothy H. Mihle, D.D.S.

SIGNED (INSURED PERSON) ______________________________ DATE ______________

AS A COURTESY WE WILL SUBMIT INSURANCE CLAIMS FOR SERVICES RENDERED. ALL PAYMENTS/CO-PAYS ARE DUE AT THE TIME OF TREATMENT.

ACCEPTED FORMS OF PAYMENT:
CASH, MASTERCARD, VISA, DISCOVER & CARE CREDIT.

TIMOTHY H. MIHLE, D.D.S., P.L.L.C.

Endodontist

1604 Physicians Drive • Ste. 101 • Wilmington, North Carolina 28401

(910) 343-3333 • (877) 671-6700

ABOUT THE PRIVACY OF YOUR HEALTH INFORMATION

Our office has always protected the privacy of the health information of our patients. The entire staff has access to patient information to provide optimum care and obtain payment for treatment. Proper safeguards are in effect to ensure confidentiality of your records. A written office policy is in place and our staff is aware of the safeguards.

Regulations require that we make available for your review a copy of our office privacy policy if you so desire. Additionally, we are required to maintain on file your signature indicating we have informed you of your privacy policy. Your signature below is appreciated.

Signature____

Date____

BELOW IS AN APPROVED LIST OF PERSON(S) THAT MAY RECEIVE INFORMATION PERTAINGING TO MY TREATMENT AND/OR ACCOUNT

NAME	BIRTHDATE	RELATION

1.____

2.____

PATIENT FINANCIAL AGREEMENT & RELEASE OF INFORMATION

The following is a statement of the Practice's financial policies, which you must read and agree to prior to any treatment.

1. PAYMENT. Payment of any unmet deductible, co-insurance, co-payment, and any charges not covered by insurance is expected at the time of your visit. We accept cash and major credit cards. In addition, we may have additional financing options available to you on or after your initial date of service.

2. INSURANCE, DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE

- It is your responsibility to confirm which treatments or procedures are covered and/or paid by insurance (including, but not limited to, any applicable exclusions, deductibles, and annual or lifetime maximums) & any referrals required by your insurance.
- As a courtesy, we will file your insurance claim for you; however, please remember that insurance is NOT a guarantee of payment. In order to bill your insurance and to meet filing guidelines, we require a copy of your insurance card and a photo ID.
- We can only approximate the percentage covered by each plan. Payment of the ESTIMATED portion as well as your co-payment is due at time of service.
- Any estimate of insurance coverage may differ from what your insurance carrier ultimately pays. You will be responsible for any charge that insurance determines to be not covered.
- **NOTE: If your doctor has recommended General Anesthesia, this does NOT mean your insurance will consider this to be a "Medically Necessary" procedure and pay for this service
- As the parent or guardian accompanying a minor, you are financially responsible for all charges, whether or not paid by insurance.
- In situations of divorce, separation, court orders, etc., the adult who signs in a minor child on the day of treatment accepts financial responsibility for payment.
- Non-covered procedures will not be filed to insurance.
- Private pay/uninsured patients: (i) you must pay in full at time of service, and (ii) you hereby acknowledge receipt of a Good Faith Estimate as required by 45 C.F.R. §149.610 by signing below.

3. BILLING AND COLLECTION.

- Payment is due as stated on any billing statement mailed, emailed or otherwise delivered to you. If we do not receive payment within fifteen (15) days of the due date, your account shall be past-due.
- Interest at the maximum rate amount allowed by law will be charged on all past due accounts.
- Past due accounts may be placed with a collection agency or attorney for collection.
- In addition to the charges for services and treatment received, you agree to be responsible for and to pay all costs and expenses incurred in the collection of amounts past due on your account including, but not limited to, collection agency fees (either 33.33% of the amount due or the maximum amount allowed by applicable law), reasonable attorney's fees and expenses, collection expenses, and court costs. If your account is turned over to collections, you hereby accept any such fees and costs as a legal and lawful debt and agree to paid said fees, including any and all resulting fees and costs. You hereby waive your right of exemption under any applicable laws.
- If your account is turned over for collections, you will no longer be able to receive services from the Practice until your delinquency is cured.

4. CONSENT TO CONTACT. The Practice and anyone contacting you on our behalf may contact you for any purpose and in any manner permitted by law. You also expressly consent to be contacted by the Practice, and anyone contacting you on our behalf, for any purpose, including billing, collection, or other account or service-related purpose, at any telephone number or physical or electronic address where you may be reached, including any wireless telephone number. We and/or anyone contacting you on our behalf may contact you in any way, such as calling, texting, emailing, sending mobile application push notifications, or using any other method of communication permitted by law. You agree that the Practice, and anyone contacting you on our behalf, may communicate with you in any manner, including through the use of an artificial or pre-recorded voice message or an automatic telephone dialing system. We may contact you on a mobile, wireless, or similar device, even if you are charged for it.

I have read the financial policies above, and my signature below indicates my agreement to these policies and acceptance of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for any services provided to me, I assume financial responsibility and will pay all such charges in full.

I hereby authorize the Practice to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the Practice all insurance benefits otherwise payable to me for the Practice's services.

______________________ Patient Name	____/____/____ Patient DOB
______________________ Patient or Responsible Party Signature	______________________ Date
______________________ Printed Name of Responsible Party (if applicable)	______________________ Relationship to Patient (if applicable)

(Version 11.2023)

By Law E-scripts only For Class II RX

Patient Name: ____

Date of Birth: ____

Pharmacy Name: ____

Phone Number:____

Address / Zip: ____