LONG H. LE, D.D.S., APC FEE SCHEDULE

Consultation and X-ray: $125-$175

D3310 Anterior RCT: $750

D3320 Bicuspid RCT: $850

D3330 Molar RCT: $950

D3331 Canals obstruction is calcification of 50% or more of the canal length or removal of separated file: $50 to $225

D3332 Incomplete root canal (fracture and/or poor prognosis upon access): $300

Retreatment of a previous root canal is an additional $150

Microsurgery, if needed vary according to the complexity of the tooth and the # of roots involved.

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As a courtesy to you, insurance forms will be completed without charge. However, please remember that your professional services are rendered and charged to the patient, not the insurance company. Your insurance contract is between you and your insurance company and is designed to be a partial aid or assistance in covering your dental cost. Ultimately, if the insurance does not pay or only pays a partial amount, the patient is personally responsible for payment. **All co-payments quoted by our office are ESTIMATED and are not actual until the claim is process and received back from insurance company. .**

Patient is responsible for full and complete payment of their accounts. If a patient is a minor, the parent accompanying the minor will be the responsible party. All payments must be made in full before treatment is completed.

I hereby authorize Dr. Long H. Le's office staff to release information related to my insurance claims. I further authorize payment directly to the dentist of benefits due me for his services as described in my insurance claims.

If your insurance does not cover your claim within 45 days of service, you will be responsible for full payment. You and your insurance shall resolve any complications in payment process including claim denials.

Payment is expected on the day of your service. They may be made in Cash, MasterCard, Visa, American Express, Discover, Capital One or Care Credit.

Patients will also be responsible for any additional expenses incurred in processing collecting delinquent receipts, including a 50% collection fee and any interest allowable on all unpaid balances.

Appointments are reserved exclusively for you and we require 48 hours notice for cancellations. Without proper notification, charges of **$75** will be applied based on the time reserved for treatment. Being 15 minutes late for treatment will be considered a no show and charges of $75 may be applied at the discretion of the dentist.

I have read and understand all of the information and agree to all of its contents. Thank you for your cooperation. If there are any questions, please don't hesitate to ask our office staff.

Signed: ____Date____________

Verified by: ____Date____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ___________________________ , have read and understand the notice of Privacy Practices concerning my health information from Long H. Le, D.D.S., APC office. A copy of this notice is available at my request at any time.

Signed: _______________________________ Date__________

Verify by: _____________________________ Date__________

For Office Use Only

Written Acknowledgement Not Obtained

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ Other:

____

____

____

UPDATE-For returning patient only

A – UPDATE – since your last visit:

1. Have you seen a medical doctor? ☐Yes ☐No

If Yes, any changes: _____

2. Have you had a change in your medication? ☐Yes ☐No
3. Have you had a change in your medical condition or had surgery? ☐Yes ☐No
4. Have you had a change in home address or home and work phone number? ☐Yes ☐No
   If yes, please inform the receptionist of the change.

Please note changes in health since last visit. If no changes, please write "none."

Signature _____ Date _____

Doctor Signature_____ Date_____

UPDATE-For returning patient only

B – UPDATE – since your last visit:

1. Have you seen a medical doctor? ☐Yes ☐No

If Yes, any changes: _____

2. Have you had a change in your medication? _____ ☐Yes ☐No
3. Have you had a change in your medical condition or had surgery? ☐Yes ☐No
4. Have you had a change in home address or home and work phone number? ☐Yes ☐No
   If yes, please inform the receptionist of the change.

Please note changes in health since last visit. If no changes, please write "none."

Signature _____ Date _____

Doctor Signature_____ Date_____

LONG H. LE, D.D.S., APC

Practice Limited to Endodontics and Microsurgery

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

THE FOLLLOWING CONFIDENTIAL INFORMATION IS FOR OUR RECORDS ONLY.

Patient: _____ Birth Date: _____
(First name) (Initial) (Last name)

Home address _____
(Street) (City) (State) (Zip)

Phone #:(___)_____ Cell#:(___)_____ Email:_____

SS #: _____(SS# is required for insurance and collection purposes)
(if no SS# given, payment in full will be required at time of service)

Patient employed by: _____How long? _____
(or parent if a minor)

Business address: _____Phone: _____

Spouse's/Parent's Name (If patient is a minor)?_____

Dental insurance? _____Insurance ID#:_____

Name of referring dentist _____A patient how long? _____

Friend or relative for emergency contact _____Phone:_____

Who is responsible for this account:?_____SS#:_____

HEALTH HISTORY

Please answer each question or by checking the appropriate box **Yes or No.**

1. Are you in good health? ☐Yes ☐No
2. Date of last physical examination?_____
3. Are you now under the care of a physician? ☐Yes ☐No

If yes, what is the condition being treated?_____

4. Have you ever had any serious illness, operation, or been hospitalized?... ☐Yes ☐No

_____

5. Are you taking any blood thinners?(Coumadin, Plavix, and etc.) ☐Yes ☐No
6. Are you taking any medication? If yes, what? _____ ☐Yes ☐No

_____ **Turn Over >>>**

7. Have you ever been premedicated with antibiotics for your dental treatment? ☐Yes ☐No
8. Are you currently taking, or have ever taken ***bisphosphonates*** like:(Fosamax, Actinel, Boniva, Zometa, Aredia, and etc.) How long?_____ ☐Yes ☐No
9. Prosthetic Joint replacement? When? (specify)_____ ☐Yes ☐No
10. Have you ever taken the drug "fen-Phen" or "Redux?"how long?_____ ☐Yes ☐No
11. Do you have or have you had any of the following. Please check **"Y" for Yes or "N" for No** – Answer all conditions

Are you allergic to:

☐Y ☐N Penicillin?
☐Y ☐N Latex?
☐Y ☐N Codeine?
☐Y ☐N Dental materials/metals?
☐Y ☐N Erythromycin?
☐Y ☐N Sulfa?
☐Y ☐N Aspirin?
☐Y ☐N Other? _____

Cardiovascular:

☐Y ☐N Angina pectoris
☐Y ☐N Congestive heart failure
☐Y ☐N Congenital heart lesions
☐Y ☐N Heart disease or attack
☐Y ☐N Heart murmur
☐Y ☐N Rheumatic fever
☐Y ☐N High blood pressure
☐Y ☐N Stroke
☐Y ☐N Mitral valve prolapsed

Hematology:

☐Y ☐N Anemia
☐Y ☐N Blood disorders
☐Y ☐N Blood transfusion
☐Y ☐N Bruise/swelling easily
☐Y ☐N Excessive bleeding
☐Y ☐N Hemophilia

Immuno/Neuro/Resp:

☐Y ☐N Tuberculosis
☐Y ☐N AIDS/HIV+
☐Y ☐N Herpes
☐Y ☐N Sinus condition
☐Y ☐N Arthritis/rheumatism
☐Y ☐N Epilepsy/seizures
☐Y ☐N Fainting or dizzy spells
☐Y ☐N Glaucoma
☐Y ☐N Asthma/emphysema

Other Health Conditions:

☐Y ☐N Kidney disease
☐Y ☐N Liver disease
☐Y ☐N Diabetes
☐Y ☐N Nervous disorders
☐Y ☐N Cancer
☐Y ☐N Chemotherapy
☐Y ☐N Radiation therapy
☐Y ☐N Ulcers
☐Y ☐N Colitis
☐Y ☐N Thyroid/parathyroid disease
☐Y ☐N Hepatitis A/B/C
☐Y ☐N Jaundice

Dental History

1. Have you ever had a local anesthetic (novocaine, etc.)?..... ☐Yes ☐No
2. Have you ever had any unfavorable reaction from local anesthetic?_____ ☐Yes ☐No
3. Have you had any serious trouble associated with any previous dental treatment? ☐Yes ☐No
4. Does dental treatment make you nervous ☐ Slightly ☐ Moderately ☐ Extremely ☐Yes ☐No
5. Have had a root canal before? How Long ago? _____ ☐Yes ☐No

Women Only

1. Are you pregnant now? If yes, How far along?_____ ☐Yes ☐No
2. Are you taking birth control pills?..... ☐Yes ☐No
3. Do you anticipate or trying to get pregnant?..... ☐Yes ☐No

Authorization

I, the undersigned, being the patient, parent, or guardian of the above minor patient, consent to the performing of whatever procedure may be decided upon to be necessary or advisable, in the opinion of the doctor and myself. I also have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that his information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I have also read and signed the attached office policy and inform consent.

SIGNATURE _____ DATE _____

DR. SIGNATURE_____ DATE_____

PAYMENT IS DUE IN FULL AT TIME OF SERVICE OR IF INSURANCE IS INVOLVED 20% DUE AT TIME OF SERVICE.

INFORMED CONSENT FOR ENDODONTICTREATMENT

_____ I hereby authorize Dr. Long Le and any other agents or employees of Dr. Le and such assistants as may be selected by any of them to treats the condition(s) described below. The procedure(s) necessary to treat the condition(s) have been explained to me, and I understand the Nature of the procedure(s) to be:

DIAG:_____

_____The prognosis for this (these) procedure(s) was described as: I understand the prognosis given before treatment can change depending on what the doctors find during treatment. Prognosis of the tooth (or teeth) can be affected by many factors that can and can't be seen clinically or on the x-rays. □Good □Fair □Guarded □Poor

_____The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure. I understand that the following may be inherent or potential risks for the treatment I will receive: (not limited to the following)

- Swelling, sensitivity, bleeding, pain, infection, discoloration of the face or gums, numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent.
- Changes in occlusion (biting), jaw muscle cramps and spasm, temporomandibular joint difficulty, exposure of the margins of crowns and bridges, loosening of teeth, crowns, or bridges, injury to existing fillings, crowns, bridges or adjacent teeth which may require replacement or treatment.
- Referred pain to ear, neck and head, delayed healing, sinus perforations, treatment failure.
- Undiagnosed splits or fractures in the root, missed canal, blocked canals, filling material beyond the root end, complications resulting from the use of dental instruments (separated sterile instruments, perforation of tooth, root, and sinus).
- Reactions or complications to injections, mediations, anesthetics that may cause heart palpitations, drowsiness and lack of awareness and coordination, and possibly death. I understand that I may receive a local anesthetic and/or other medication. In rare instances patients have a reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. **Depending on the anesthesia and medications administered, I may need a designated driver to take me home.** Rarely, temporary or permanent nerve injury can result from an injection. I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications.
- Twisted, curved, accessory, or blocked canals may prevent removal of all inflamed or infected pulp. Since leaving any pulp in the root canal may cause your symptoms to continue or worsen, this might require an additional procedure called an *apicoectomy.* Through a small opening cut in the gums and surrounding bone, any infected tissue is removed and the root canal is sealed. An apicoectomy may also be required if your symptoms continue and the tooth does not heal.
- I understand teeth that receive root canal treatment may be more prone to cracking and breaking over time, which may require removal and replacement with a bridge, partial denture or implant. In some cases, root canal treatment may not relieve all symptoms. The presence of gum disease (*periodontal disease*) can increase the chance of losing a tooth even though root canal treatment was successful. I understand that root canal treatment may not relieve my symptoms, and I may need my tooth extracted.
- Antibiotics may inhibit the effectiveness of birth control pills.
- Osteonecrosis of the bone can occur in patients that are taking bisphosphonate like fosamax, Actinel, Boniva, Zometa, Aredia, and etc.

_____I understand that endodontic treatment (root canal treatment, retreatment, or surgery) is an **attempt** to retain a tooth that may otherwise require extraction. Although endodontic treatment has a high degree of success, it cannot be guaranteed or warranted. Occasionally a tooth that has had endodontic treatment, despite all our efforts, may require retreatment, surgery, or even extraction. The tooth (or teeth) will require a final restoration such as a new filling or crown. Your general or regular dentist should place a final restoration within **one to three weeks** after the endodontic treatment has been completed.

_____I have been given the opportunity to question the doctor concerning the nature of treatment, the risks and benefits of the treatment, and the alternatives to this treatment, including no treatment at all. I understand that depending on my diagnosis, alternatives to root canal treatment may exist which involve other disciplines in dentistry. Extracting my tooth is the most common alternative to root canal treatment. It may require replacing the extracted tooth with a removable or fixed bridge or an artificial tooth called an *implant.* I have asked my dentist about the alternatives and associated expenses. I understand that if I do not have root canal treatment, my discomfort may continue and I may face the risk of a serious, potentially life-threatening infection, abscesses in the tissue and bone surrounding my teeth and eventually, the loss of my tooth and/or adjacent teeth. My questions have been answered to my satisfaction regarding the procedures, their risks, benefits, and costs. This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment.

_____ I give consent for the proposed treatment as described above.

□ I refuse to give my consent for the proposed treatment as described above. I have been informed of the potential consequences of my decision to refuse treatment.

Patient's signature _____ Date _____

Doctor's signature _____ Date _____

Witness' signature_____ Date_____

Guide to Dental Benefits

If you have dental insurance, **as a courtesy to you**, we will be happy to bill your insurance company. We will call your insurance company, and do our best to provide a **treatment estimate**, but if the insurance company is not updated from your other recent dentist visits in the past month, the estimate might be incorrect**. Please feel free to call your insurance company to verify for yourself.** We are here to help you out to the best of our abilities and help you understand your dental benefit. Insurance company that sign you up will tell you all the good things but never tells you about fine print limitations. Our office will go over a treatment plan and estimated cost with you prior to beginning treatment. Any **copayment or estimated portion not covered by insurance is due at the time of service**. If no insurance is present, payment in full is due at time of service. Any remaining balances after we have exhausted our effort to resolving your claim with your dental insurance are your responsibility.

Your dental benefit **may vary** for a number of reasons, such as:

- You have already used some or all of the benefits available from your dental insurance, for example, 2 consultations may only be allow a year by some insurances.
- Some insurances may only allow 1 root canal or treatment per 12 or 24 months or lifetime.
- Your annual maximum dental benefit for the year is cumulative for all the dentists seen in that year.
- Your insurance plan may paid only a percentage of the fee charged by your endodontist.
- The treatment you needed was not a covered benefit by your particular plan.
- You have not yet met your plan's deductible.
- You have not reached the end of your plan's waiting period and are currently ineligible for coverage.
- Examples that may not be covered by your insurance are an incomplete root canal (d3332) due to vertical root fracture. Root canal obstruction (d3331) due to severely calcified canals or broken instrument in the canal.
- Not all fracture/crack teeth are created equal. If an obvious vertical root fracture is evident, then extraction is the only treatment.
- Some vertical root fracture can only be seen by using a 20x power microscope. If the fracture is only in the crown portion of the tooth, where the porcelain or metal crown can seal it, the tooth can be saved. If the fracture has gone into the root, where it can't be sealed, then the tooth must be extracted because of bacterial leakage.
- If a previous crown was placed over a fracture/crack in the tooth, this only slows down the crack, it does not stop it. Therefore, cracked teeth have an unpredictable prognosis.
- Dr. Le will always be honest about the prognosis of the treatment and have you consider all the options versus the money you will be spending. If you put a crown on an already deep fracture/cracked tooth, the bacterial leakage will cause the root canal to fail in 6 to 12 months even though you don't have pain.
- The cost **without insurance** is $300.00 for an incomplete root canal versus $950.00 for a complete root canal. If a vertical root fracture is discovered under the crown while doing the root canal, you would be charged for an incomplete root canal and Dr. Le will advise you to have the tooth extracted. We have to charge for the incomplete root canal because we have reserved a one hour time slot to treat your tooth. This still saves you money in the long term because you will not have to put a new crown on an unpredictable tooth that may need to be extracted in the near future.
- Having no pain is not an indicator that there is nothing wrong. You can have an infection that is growing underneath your tooth and still have no pain. It can flare up at any time.
- Taking antibiotic does not take care of a root canal problem but only take care of the symptoms for short period of time. The infection will flare up even worst when it comes back. Only doing the root canal or extraction can resolve a root canal problem. The prognosis of the tooth is dependent on many factors, so the sooner it is done the better.
- **If you need a copy of anything you sign today** please ask the receptionist. We are a transparent office, so feel free to ask us any questions. We will do our best to answer them to the best of our abilities.

The contract you personally or your employer negotiated with your insurance carrier defines your dental benefits. Please read the benefit or insurance plan booklet provided by your employer so that you better understand your benefits. Various dental plans cover endodontic procedures at different payment levels and, as a result, your payment portion may vary.

We Are Here For You, Call Us at 760-510-1810.

SIGNATURE _____ DATE _____

Verified by: _____ DATE_____