Welcome to Our Office!

PATIENT INFORMATION

Please circle: Mr. Mrs. Ms. Dr. Other_____

_____ _____ _____ _____

(Print) LAST NAME FIRST MI NAME PREFERENCE

Address: _____ Apt:____ City: _____ State:____ Zip: _____
(IF P. O. BOX GIVE STREET ADDRESS ALSO)

Home #: _____ Work #: _____ Cell #:_____ Email: _____

Social Security Number:_____-_____-_____ Date of Birth: _____ Sex:☐M ☐F Spouse's Name: _____

Your Employer: _____ Employer's Address: _____

Physician: _____ General Dentist: _____ Referred By: _____

How did you hear about us? ☐Dentist ☐Friend ☐Internet ☐Telephone Book ☐Other _____

Emergency contact: Name: _____ Work #:_____ Home #: _____

Preferred pharmacy: _____ Cross streets: _____

MEDICAL HISTORY: Please check the answer that is right for you (past or present) with "Yes," "No," or "UK" (unknown).

Y	N	UK		Y	N	UK		Y	N	UK		Y	N	UK	
☐	☐	☐	Artificial Heart Valve	☐	☐	☐	Tuberculosis	☐	☐	☐	High Blood Pressure	☐	☐	☐	Diabetes
☐	☐	☐	Rheumatic Fever	☐	☐	☐	Hepatitis A, B, or C (CIRCLE)	☐	☐	☐	Heart Murmur	☐	☐	☐	Thyroid disease
☐	☐	☐	Mitral Valve Prolapse	☐	☐	☐	HIV Positive	☐	☐	☐	Heart Surgery	☐	☐	☐	Angina Pectoris
☐	☐		Drug Addiction	☐	☐	☐	Pain in Jaw Joints	☐	☐	☐	Bleeding Disorders	☐	☐	☐	Artificial Joint
☐	☐	☐	Congenital Heart Defects	☐	☐	☐	Heart Attack/Stroke (CIRCLE)	☐	☐	☐	Heart Pacemaker	☐	☐	☐	Epilepsy/Seizures (CIRCLE)

Any other medical illnesses or conditions? _____

Have you ever had an unusual reaction to latex, anesthetics, or drugs such as Penicillin, Erythromycin, Novacaine, Codeine, Aspirin, Sulfa, or any other medications? ☐Yes ☐No ☐Unknown

If yes, please explain: _____

What medications are you currently taking? _____

_____

Have you ever taken Bisphosphonates (osteoporosis medication)? ☐Yes ☐No ☐Unknown

If yes, please list: _____

Are you currently taking a blood thinner? ☐Yes ☐No ☐Unknown

If yes, please list: _____

Are you able to take Ibuprofen? ☐Yes ☐No ☐Unknown

Are you required to take antibiotic premedication prior to dental appointments? ☐Yes ☐No ☐Unknown

If yes, list reason (heart condition, joint replacement) and name of antibiotic: _____

_____

If joint replacement, date of surgery: _____

Women: Are you pregnant? ☐Yes ☐No If yes, how far along? _____

How are you feeling today?

☐Confident ☐Happy ☐Curious ☐Frightened ☐Anxious ☐Pained

Continue on reverse side ➡

PRIMARY DENTAL INSURANCE

Name of Insured Person (Employee):_____ Relationship to Patient: _____

Member ID#: _____ Date of Birth: _____

Employer/Retired:_____Length of Employment: _____

Name of Insurance Company: _____Group#:_____Phone#:_____

Is the patient a full time student: ☐ Yes ☐ No School: _____

SECONDARY DENTAL INSURANCE

Name of Insured Person (Employee):_____ Relationship to Patient: _____

Member ID#: _____ Date of Birth: _____

Employer/Retired:_____Length of Employment: _____

Name of Insurance Company: _____Group#:_____Phone#:_____

Complete only if patient is a minor:

Responsible Party: _____ Date of Birth: _____ Social Security #: _____

Address: _____ City/State: _____ Zip: _____

Home #:_____Work #: _____Relation to Patient: _____

The purpose of **Endodontic Treatment** (root canal therapy) is to save your tooth rather than remove it. Although this treatment has a high rate of success, it cannot be guaranteed. A tooth that has had a root canal may require re-treatment, surgery or eventual extraction. Before any treatment is started, the reason(s) will be explained as well as alternative modes of therapy. Occasionally, an antibiotic may be indicated. This will be discussed in advance.

After treatment you must return to your general dentist to have your tooth protected with a permanent filling or crown. This is not included in our cost.

- I consent to necessary treatment and authorize the release of any information needed for continued care.
- I authorize the release of information to my insurance company & payment of benefits directly to provider. Any balance not paid by my insurance will be due within two weeks of the statement date.
- I am financially responsible for fees incurred at the time of service. In the event my account becomes delinquent, I understand a **LATE FEE** up to **$10** and/ or a **SIMPLE INTEREST CHARGE** will be added to the account. The **INTEREST CHARGE** will be a periodic rate of **1.5%** per month, which is an **ANNUAL PERCENTAGE RATE** of **18%**, applied to the last month's balance. In addition, an additional **30%** of the principal balance due will be added to help cover the cost of collection. I understand that I am responsible for attorney's fees, interest and court costs should it become necessary that legal action be taken, and that a credit report will be obtained for the sole purpose of collecting a delinquent balance.

_____ _____

Signature of Patient (Parent/Guardian of a minor) **Date**