

NAME/MS. DATE ____/____/____
MISS/MR. SS# ____--____--
MRS./DR. _____

LAST MI FIRST
ADDRESS _____
STREET CITY/TOWN ZIP DATE OF BIRTH ____/____/____

HOME PHONE () _____ CELL () _____ E-MAIL _____

OCCUPATION _____ PLACE OF WORK _____ WORK PHONE () _____

REFERRING DENTIST _____
NAME CITY/TOWN

CONTACT IN CASE OF EMERGENCY _____ RELATIONSHIP _____ PHONE() _____

REASON FOR THIS VISIT _____

CHECK IF YOU HAD BEEN CARED FOR BY ANY OF THE FOLLOWING:

ORTHODONTIST PERIODONTIST ORAL SURGEON OTHER NAME _____

PHYSICIAN'S NAME _____ PHONE () _____

ARE YOU NOW OR HAVE YOU RECENTLY BEEN UNDER A PHYICIAN'S CARE? Y / N

IF YES, FOR WHAT REASON _____

CHECK IF YOU ARE ON ANY OF THE FOLLOWING MEDICATION:

STEROID SYNTHROID COUMADIN PLAVIX ASPIRIN

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, IF ANY _____

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

- | | | |
|---|--|---|
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> HERPES |
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> HIV |
| <input type="checkbox"/> ASTHMA / HAY FEVER | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> SINUS PROBLEM | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> DIZZY SPELLS / SEIZURES |
| <input type="checkbox"/> EAR INFECTION | <input type="checkbox"/> ARTIFICIAL VALVE | <input type="checkbox"/> EPILEPSY |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> PACE MAKER | <input type="checkbox"/> NEUROLOGICAL DISORDER |
| <input type="checkbox"/> LUNG DISEASE | <input type="checkbox"/> IRREGULAR HEARTBEAT | <input type="checkbox"/> GLAUCOMA |
| <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> HEART ATTACK WHEN _____ | <input type="checkbox"/> DRUG OR ALCOHOL ADDICTION |
| <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> HEART SURGERY | <input type="checkbox"/> PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> HEPATITIS / JAUNDICE | <input type="checkbox"/> ABNORMAL BLEEDING | <input type="checkbox"/> CANCER _____ |
| <input type="checkbox"/> SLOW HEALING | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> CHEMOTHERAPY |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> RADIATION THERAPY |
| <input type="checkbox"/> STOMACH ULCERS | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> MAJOR OPERATION _____ |
| <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> PROSTHETIC JOINTS WHEN _____ |
| <input type="checkbox"/> OTHER _____ | | |

CHECK IF YOU HAVE HAD SENSITIVITY OR ALLERGIC RESPONSE TO ANY OF THE FOLLOWING:

LOCAL ANESTHETICS EPINEPHRINE ASPIRIN CODEINE LATEX IODINE ANTIBIOTICS _____

OTHERS _____

HAVE YOU EVER TAKEN ANTIBIOTICS BEFORE DENTAL PROCEDURES? Y / N NAME _____

DO YOU SMOKE TOBACCO? Y / N IF YES, HOW MUCH? _____

WOMEN ONLY: ARE YOU PREGNANT? Y / N HOW MANY MONTHS? _____ ARE YOU BREAST FEEDING? Y / N

PLEASE INDICATE ANY SPECIAL CONCERNS RELATED TO YOUR DENTAL TREATMENT _____

I HAVE REVIEWED THE INFORMATION ON THIS QUESTIONNAIRE AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____/_____/_____
SIGNATURE OF PATIENT OR PARENT IF PATIENT IS A MINOR OR RESPONSIBLE PARTY RELATIONSHIP TO PATIENT DATE ____/____/____

PATIENT BILLING AND DENTAL INSURANCE INFORMATION

Financially Responsible Party (Name) _____ SS# ___/___/___

Patient (Print Name) _____ SS# ___/___/___

Financially Responsible Party (Address) _____
City State Zip

DENTAL INSURANCE COMPANY INFORMATION (If you do not have dental insurance to cover endodontic services, please proceed to the AUTHORIZATIONS AND FINANCIAL AGREEMENT)

Name of the Dental Insurance Company: _____

Address: _____
City State Zip

Subscriber Name (Print) _____

a. Date of Birth (MM/DD/CCYY) ___/___/___

b. Address _____
City State Zip

c. Subscriber Identifier (SSN or ID#) _____

d. Plan / Group Number _____

e. Employer Name _____

Employer Address _____
City State Zip

Patient's Relationship to Primary Subscriber (Please Circle Below)

Self Spouse Dependent Child Other (Explain) _____

AUTHORIZATIONS

I authorize insurance payments be made directly to the doctor for services rendered and understand that I am financially responsible for charges regardless of insurance coverage. To the extent permitted by law, I consent to the release of protected medical information to third parties as specified by HIPAA laws regarding Privacy Practices for the purpose of enabling the doctor to obtain payment for dental services rendered. I understand that if the third party is not a health care provider the released information may no longer be protected. I understand that I may revoke this authorization at any time and that it will automatically terminate one year from the date the dental services have been completed.

Patient's or Guardian's Signature: _____ Date ___/___/___

Financially Responsible Party's Signature _____ Date ___/___/___

FINANCIAL AGREEMENT

I agree that I am financially responsible for all services rendered by the doctor regardless of insurance coverage. Payment in full is due at the time dental services are rendered, unless other payment arrangements have been approved in writing in advance by our staff. I agree that all balances 30 days past due (after all insurance claims are processed) are subject to late charges at the rate of \$10.00 per month. I agree to pay reasonable attorney's fees as limited by law and all costs of collection in case of default on payment of the account. **I hereby certify that I have read and understand this form, and have received a copy of this document.**

Financially Responsible Party's Signature _____ Date ___/___/___