MANNE & BORER
ENDODONTICS AND MICROSURGERY, PL

Welcome To Our Practice

Thank you for trusting us with your dental care.
We promise to do our best to provide you with the finest care available.
If you have any questions, please do not hesitate to contact us.

Date _____

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Name _____ Birth Date _____

Sex ❑ M ❑ F Address _____ City _____ State _____ Zip _____

❑ Minor ❑ Married ❑ Widowed ❑ Single ❑ Separated ❑ Divorced ❑ Partnered for _____ years

Home Phone _____ Cell Phone _____ E-mail _____

Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Dentist _____ Medical Doctor _____

Whom may we thank for referring you? *(e.g., General Dentist)* _____

Contact in case of emergency _____ Phone _____ Relation to Patient _____

Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card Employed: ❑ Full Time ❑ Part Time ❑ Retired

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other *(If self, skip to next section)*

Name _____ S.S.# _____ Birth Date _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

Currently a patient in our office? ❑ Yes ❑ No E-mail _____ Cell Phone _____

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Insurance Company Name _____

Insurance Company Address _____ City _____ State _____ Zip _____

Insurance Company Phone _____

Group # _____ **ID #** _____

Insured Party _____ Relation to Patient _____

Sex: ❑ M ❑ F Birth Date _____ S.S # _____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell Phone _____ Email _____

I.D. # _____

~ over ~

MEDICAL HISTORY

Are you in good health? ❑ Yes ❑ No Height_____ Weight_____ Are you under the care of a physician? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N	
❑	❑	Rheumatic Fever	❑	❑	Hay Fever / Sinus Problems	❑	❑	Thyroid Trouble
❑	❑	Mitral Valve Prolapse	❑	❑	Respiratory Problems	❑	❑	Diabetes
❑	❑	Heart Murmur	❑	❑	Tuberculosis	❑	❑	HIV
❑	❑	High Blood Pressure	❑	❑	Emphysema	❑	❑	Sexually Transmitted Diseases
❑	❑	Low Blood Pressure	❑	❑	Blood Transfusion	❑	❑	Malignant Hyperthermia
❑	❑	Chest Pain / Angina	❑	❑	Blood Disorder	❑	❑	Low Blood Sugar
❑	❑	Heart Attack(S)	❑	❑	Bruise Easily	❑	❑	Kidney Trouble
❑	❑	Irregular Heart Beat	❑	❑	A History of Drug Abuse	❑	❑	Are You on Dialysis
❑	❑	Cardiac Pacemaker	❑	❑	Eye Disease / Glaucoma	❑	❑	Arthritis / Joint Disease
❑	❑	Heart Surgery	❑	❑	Abnormal Bleeding	❑	❑	Osteoporosis / Osteopenia
❑	❑	Bronchitis / Chronic Cough	❑	❑	Jaundice / Liver Disease	❑	❑	Osteonecrosis
❑	❑	Chronic Fatigue / Night Sweat	❑	❑	Hepatitis A B C (circle)	❑	❑	Stomach Ulcers
❑	❑	Mental Health Problems	❑	❑	Infectious Mononucleosis	❑	❑	Contagious Diseases
❑	❑	Damaged Heart Valves	❑	❑	Gallbladder Trouble	❑	❑	Delay in Healing
❑	❑	Are You Immunosuppressed? (Possibly From Transplant Surgery)	❑	❑	Fainting Spells	❑	❑	Anemia
			❑	❑	Convulsions / Epilepsy	❑	❑	Tumor or Growth
❑	❑	Asthma	❑	❑	Stroke	❑	❑	Radiation / Chemotherapy

MEDICATION and ALLERGIES

Have you been advised to pre-medicate for medical reasons *(e.g., antibiotics)* prior to dental treatment? ❑ Yes ❑ No

List any other medication(s) you are taking (including natural, herbal, or homeopathic products) that are not listed below:

_____

Are you now taking or have you taken:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Blood thinners	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
❑	❑	Any bone density medication or Bisphosphonates *(Aredia, Zometa, Fosamax, Actonel)*									

Are you allergic to or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Latex
❑	❑	Valium or other tranquilizers	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Amoxicillin
❑	❑	Soy	❑	❑	Eggs / Yolk						

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1 – 4 below for women only:

(Women Note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* **X** _____ **Reviewed by:** _____ **Date:** _____

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* **X** _____ **Date:** _____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* **X** _____ **Date:** _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: *(Parent or Guardian if minor)* **X** _____ **Date:** _____