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

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 ____________

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 ____________________

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MEDICAL HISTORY

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

Explain: ____________________

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

Y N		Y N		Y N	
❑ ❑	Rheumatic Fever	❑ ❑	Blood Disorder	❑ ❑	HIV
❑ ❑	Mitral Valve Prolapse	❑ ❑	Bruise Easily	❑ ❑	Sexually Transmitted Diseases
❑ ❑	Heart Murmur	❑ ❑	Abnormal Bleeding	❑ ❑	Low Blood Sugar
❑ ❑	Blood Pressure - High or Low	❑ ❑	A History of Drug Abuse	❑ ❑	Kidney Trouble
❑ ❑	Chest Pain / Angina	❑ ❑	Eye Disease / Glaucoma	❑ ❑	Osteoporosis / Osteopenia
❑ ❑	Heart Attack(S)	❑ ❑	Jaundice / Liver Disease	❑ ❑	Osteonecrosis
❑ ❑	Irregular Heart Beat	❑ ❑	Hepatitis A B C (circle)	❑ ❑	Contagious Diseases
❑ ❑	Cardiac Pacemaker	❑ ❑	Fainting Spells	❑ ❑	Delay in Healing
❑ ❑	Heart Surgery	❑ ❑	Convulsions / Epilepsy	❑ ❑	Tumor or Growth
❑ ❑	Damaged Heart Valves	❑ ❑	Stroke	❑ ❑	Radiation / Chemotherapy
❑ ❑	Mental Health Problems	❑ ❑	Thyroid Trouble	❑ ❑	Vertigo
❑ ❑	Asthma	❑ ❑	Diabetes	❑ ❑	Issues Laying Back In a Dental Chair
❑ ❑	Respiratory Problems	❑ ❑	Are You Immunosuppressed? *(Possibly From Transplant Surgery)*		
❑ ❑	Tuberculosis				

Are you OR have you taken osteoporosis medications? ❑ Yes ❑ No If Yes, what ____________________

MEDICATION and ALLERGIES

List medication(s) you are taking: ____________________

____

____

____

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

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.

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:** ____________