endodontics P.C.

## PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____ Sex M F

Date of Birth _____ SSN _____ Phone _____

Street Address _____ City _____ State _____ Zip _____

Referring Dentist _____ Emergency Contact _____ Phone _____

*If you are completing this form for another person:* Name _____ Relationship _____

## INSURANCE INFORMATION

*Primary* Insurance Policyholder _____ Same as Patient (skip to Subscriber ID line)

Policyholder Name _____ SSN _____ Date of Birth _____

Subscriber ID _____ Insurance Company _____ Employer _____

*Secondary* Insurance Policyholder _____ Same as Patient (skip to Subscriber ID line)

Policyholder Name _____ SSN _____ Date of Birth _____

Subscriber ID _____ Insurance Company _____ Employer _____

## MEDICATIONS & ALLERGIES

Do you require a pre-medication for dental procedures? Yes No If yes, did you take your pre-medication today? Yes No N/A

Are you allergic to latex? Yes No If yes, specify reaction: _____

Are you allergic to any medications (including novocaine, penicillin, codeine)? Yes No If yes, please list and specify reaction:

_____

Please list all medications you are currently taking (or provide separate sheet) _____

_____

_____

## HEALTH CONDITIONS (PLEASE CIRCLE)

| | | | |
|---|---|---|---|
| Stroke | Hepatitis A, B, or C | Tuberculosis | Orthopedic Joint Replacement |
| Heart Condition | Jaundice | Artificial Heart Valve | Excessive Bleeding |
| High Blood Pressure | Kidney Disease | Narcolepsy | Serious Head or Mouth Injury |
| Rheumatic Fever | Diabetes | AIDS or HIV Infection | <u>WOMEN ONLY</u> |
| Asthma | Epilepsy | Fainting Spells or Seizures | Pregnant How many weeks _____ |
| Stomach Problems | Problems with Previous Dental Treatment | | Nursing |

Provide details for any "Yes" responses: _____

Do you have any other disease, condition, problem, or concern not listed above that the doctor and his/her staff should know about?

_____

_____

## CONSENTS & AUTHORIZATIONS

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that the doctor and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold the doctor, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

I understand that I have certain rights to privacy regarding my protected health information and have received a copy of these rights. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize this office to use and disclose my protected health information to provide treatment. I understand the office's Financial Policy that was provided. I assume financial responsibility as outlined in the Policy and Fee Schedule. I authorize this office to file any insurance on my behalf and to provide any medical information necessary to do so.

I authorize this office to perform diagnostic procedures (examination, digital x-rays) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize this office to perform any agreed upon treatment needs. I understand there is a slight chance of prolonged numbness of the tongue or lips following local anesthetic injection. I also understand upon completion of root canal therapy in this office, the patient may be referred to his/her general dentist for permanent restoration such as a crown or filling.

Signature of Patient/Legal Guardian _____ Date _____