

KEITH V. KRELL, D.D.S.
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TY ERICKSON, D.D.S.
THOMAS D. BECKER, D.D.S.
LINDSEY J. MEDER, D.D.S.

Have you seen our doctors before? Yes _____ No _____ (The following confidential information is for our records only)

Dr. Mr. _____ Age: _____ Birth Date: _____
Patient: _____
Mrs. Ms. _____ Soc. Sec. No.: _____

Home Address: _____ Phone: _____
Street _____

City _____ Zip _____ E-Mail: _____
Patient Employed by: _____ Occupation: _____

Business Address: _____ Phone: _____

Name of Spouse: _____

Spouse Birth Date: _____ Soc. Sec. No.: _____

Spouse Employed by: _____ Occupation: _____

Business Address: _____

If patient is a minor, who is financially responsible for the patient: _____

Address of responsible person: _____ Soc. Sec No.: _____

Responsible person employed by: _____ Birth Date: _____

Name of referring dentist: _____

HEALTH HISTORY

YES NO

- 1. Are you in good health? _____
- 2. Have you been treated by a physician during the past five years? (other than routine check ups) _____
- 3. Any serious illnesses or contagious diseases? _____
- 4. Are you taking any medication now? Please list, _____
- 5. Are you sensitive or allergic to any medications, including: **novocaine, penicillin, codeine, or latex, any other medications? (Please circle)** _____
- 6. Have you ever had an unfavorable reaction following dental treatment? _____
- 7. Have you ever had excessive bleeding requiring special treatment? _____
- 8. Have you ever had any of the following illnesses? If so, please circle. Stroke, heart trouble, high blood pressure, rheumatic fever, asthma, tuberculosis, hepatitis, jaundice, kidney disease, diabetes, epilepsy, nervous disorders, heart murmur, heart problems, artificial joint replacement, artificial heart valve, stomach problems? _____
- 9. Do you regularly take dietary supplements or herbal medicines? _____
- 10. Female patients, are you pregnant, (which month are you due? _____) _____

PERMISSION FOR EXAMINATION, ROOT CANAL PROCEDURE, AND LOCAL ANESTHETIC

I, the undersigned, being the patient (or parent or guardian of the above minor), consent to the performing of the procedure which may be decided upon to be necessary or advisable, in the opinion of the Doctor. 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 I will be referred to my general dentist for permanent restoration such as a crown, cap, jacket onlay or filling. It is our policy for the Endodontic fee to be paid upon completion of treatment. If insurance is involved, forms will be completed by our office as a courtesy. You are expected to know your policy limits. Medical insurance does not cover dental procedures except in case of an accident. Please refer to our Notice of Privacy Practices to protect your private health information. Signing this form acknowledges receipt of our Privacy Practices.

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM AND PAYMENT DIRECTLY TO ENDODONTICS, P.C. I AGREE TO TAKE CARE OF ANY REMAINING BALANCE AFTER INSURANCE BENEFIT.

Date _____ Signature _____

Primary Dental Insurance Co. _____

Policy Holder's Name _____ Soc. Sec. No. _____

2nd Dental Insurance Co. _____

Policy Holder's Name _____ Soc. Sec. No. _____

Next Apporintment: _____ Units Tooth#: _____ Proc Code: _____