endodontics P.C.

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PATIENT INFORMATION

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

Date of Birth: _____ SSN: _____ Referring Dentist _____

Primary Address: _____

Primary Phone: _____ Secondary Phone: _____

Emergency Contact: _____ Relationship: _____ Phone number: _____

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

INSURANCE INFORMATION

Name of Policyholder: _____ Subscriber ID: _____

Insurance Provider: _____ Policyholder's Employer: _____

SSN of Policyholder (if insurance card is not provided): _____

MEDICATIONS & ALLERGIES

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

_____

_____

Are you allergic to any medications (including novocaine, penicillin, codeine)? If so, please list and specify reaction: _____

_____

Are you allergic to latex? (please circle and specify reaction) Yes No

HEALTH CONDITIONS (PLEASE CIRCLE)

Stroke	Hepatitis A, B, or C	Tuberculosis	Orthopedic Total Joint Replacement
Heart Condition	Jaundice	Artificial Heart Valve	Excessive Bleeding
High Blood Pressure	Kidney Disease	Narcolepsy	Serious head or mouth injury
Rheumatic Fever	Insulin-dependent diabetes	AIDS or HIV infection	**— WOMEN ONLY —**
Asthma	Epilepsy	Fainting spells or seizures	Pregnant How many weeks?_____
Stomach Problems	Problems with previous dental treatment		Nursing

Please provide additional details for any "Yes" Responses: _____

_____

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

If so, please explain: _____

_____

CONSENTS AND 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: _____