endoPC Root Canal Specialists

PATIENT

First Name _____ M.I. ____ Last Name _____

Date of Birth _____ Sex M F Gender Identity _____ Occupation _____

Phone _____ SSN _____ Referring Dentist _____

Mailing Address _____ City _____ State ____ Zip _____

Emergency Contact Name & Relationship _____ Phone _____

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

DENTAL INSURANCE

Primary Dental Insurance Policy

Policyholder Name _____ SSN _____ Date of Birth _____

Subscriber ID _____ Insurance Company _____ Employer _____

Secondary Dental Insurance Policy

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 novocain, penicillin, codeine)? Yes No If yes, please list and specify reaction:

_____

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

_____

_____

Preferred Pharmacy _____

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	WOMEN ONLY
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 there are certain rights to privacy regarding protected health information and have received a copy of these rights. These rights are given 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, including for coordination of care with other healthcare providers (general dentist, oral surgeon, etc.)· I understand the office's Financial Policy that I was provided and assume financial responsibility for all procedures completed in this office.· 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, CBCT) 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 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 _____