Exton, West Chester and Paoli Endodontics
root canal specialists

Exton
665 Exton Commons
Exton, PA 19341
(610) 524-1610

West Chester
606 East Marshall St.
Suite 204
West Chester, PA 19380
(610) 431-7025

Paoli
1460 Russell road
Suite 203
Paoli, PA 19301
(484) 329-8903

Dr. Samuel Kratchman, D.M.D | **Dr. Kenneth Lee, D.M.D.** | **Dr. Allen Yang, D.M.D.** | **Dr. Ameir Eltom, D.D.S.** | **Dr. Lindi Orlin, D.D.S.**

The best patient-doctor relationships are maintained when there is a complete understanding of the treatment rendered and the fees charged. When endodontic treatment is complete, your tooth will require, for its protection, a permanent restoration or crown. That service is provided by your general dentist and is not included in our fee. We appreciate your trust in us.

Last Name _____ First Name _____ Middle Name _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Social Security # _____

Birth Date _____ E-mail Address _____

Name of General Dentist _____

Who should we thank for this referral? _____

Name of Person responsible for this account _____

My payment will be made by: ◯ Cash ◯ Check ◯ Credit Card (American Express, Visa, MasterCard or Discover)

Do you have Dental Insurance? ◯ Yes ◯ No

Subscriber's Name _____ Relationship _____

Insurance Co. _____ Phone # _____

Insurance Address _____

Employer Name _____

Subscriber's Birth Date _____ Social Security # _____

Group No. _____ Insurance ID # _____

OUR PAYMENT POLICY

For patients that do not have insurance, or those with insurance plans that we do not participate in, payment is due at the time services are rendered. We accept VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, and CARE CREDIT. For patients that have dental plans that we do participate in, your copayment is due at the time services are rendered. If we do not participate with your insurance plan, we will submit to your insurance for reimbursement to you as a courtesy.

OUR INSURANCE POLICY

When you schedule your appointment, we ask that you provide to us, detailed insurance information. We participate with Delta Dental, Met Life, Aetna PPO, Cigna PPO, Guardian, Assurant, Humana, Ameritas, Dentemax and Fidelio. Your copayment is due the day services are rendered.

Date _____ Signature _____

HEALTH QUESTIONNAIRE

DENTAL CARE IS PART OF YOUR OVERALL HEALTH. IN ORDER THAT WE MAY PROVIDE YOU WITH THE BEST POSSIBLE CARE, PLEASE COMPLETE THIS FORM AS THOROUGHLY AS POSSIBLE.

Have you had any of the following problems or conditions?

Rheumatic Fever ◯ Yes ◯ No

Polio ◯ Yes ◯ No

Jaundice ◯ Yes ◯ No

Heart Problems ◯ Yes ◯ No

If yes, what type

Diabetes ◯ Yes ◯ No

Thyroid Problems ◯ Yes ◯ No

Pregnant now? ◯ Yes ◯ No

Bleeding or Clotting Problems ◯ Yes ◯ No

Nephritis (kidney) ◯ Yes ◯ No

Surgery ◯ Yes ◯ No

If yes, what type

Blood Pressure Problems ◯ Yes ◯ No

If yes, what type

T.B. ◯ Yes ◯ No

Cancer ◯ Yes ◯ No

Sinus ◯ Yes ◯ No

Hepatitis ◯ Yes ◯ No

Epilepsy ◯ Yes ◯ No

Are you HIV positive? ◯ Yes ◯ No

If yes to any of the above, please explain

1. Are you on any daily medications? If yes, please list.

2. Do you have any drug or latex allergies?

3. Are you taking any medication for your current Dental problem?

4. Have you ever had any problems with local Anesthetic?

5. Is there any other information we should have?

6. Do you need to take antibiotics before dental visits for any medical reason? ◯ Yes ◯ No

7. Female patients only. Are you pregnant? ◯ Yes ◯ No

HIPAA (Health Insurance Portability & Accountability Act): I have received a copy of this office's Notice of Privacy Practices, Consent for Use and Disclosure of Health Information & Release Form.

Print Name

Date _____ Signature _____

Print Form