

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 \_\_\_\_\_