Account #_____

(THE FOLLOWING CONFIDENTIAL INFORMATION IS FOR OUR RECORDS ONLY.)

Patient:_____ Date of Birth:_____

Mailing Address: _____

City:_____State:_____ Zip: _____ SSN:_____

Home Phone: _____Cell Phone: _____

Patient Employer:_____Occupation:_____

Spouse:_____Date of Birth:_____SSN:_____

Spouse Employer:_____Occupation: _____

IF MINOR ❑ Responsible Parent:_____ SSN:_____

Parent Employer:_____Occupation: _____

Parent's Cell:_____Date of Birth: _____

Primary Insurance Co._____Group #:_____

Subscriber Name:_____ SSN/ID #:_____

Employer:_____ Date of Birth: _____

Secondary Insurance Co._____Group #: _____

Subscriber Name:_____ SSN/ID #:_____

Employer:_____ Date of Birth: _____

FAMILY DENTIST:_____ Phone: _____

REFERRING DENTIST:_____ Phone: _____

PHYSICIAN:_____ Phone: _____

PHARMACY:_____ Phone: _____

OVER FOR HEALTH INFORMATION

HEALTH HISTORY

	Yes	No
1. Are you sensitive or allergic any medications?	❑	❑

Medication Name	Reaction

	Yes	No
2. Have you ever had or have any of the following? **IF SO PLEASE CIRCLE:** Artificial heart valve, artificial joint, asthma, diabetes, epilepsy, heart trouble, hepatitis, high blood pressure, HIV positive, kidney trouble, nervous disorders, stroke.	❑	❑
3. Have you ever had any other serious illness?_____	❑	❑
4. Female patients: Are you pregnant? Due date?_____	❑	❑
5. Are you taking any medication? **PLEASE LIST BELOW**	❑	❑

Medication Name	Dose (mg, freq)	Reason

Notes: (For Doctor/Staff use only)

PERMISSION FOR DIAGNOSIS AND TREATMENT

I, the undersigned, being the patient, parent or guardian of the above minor patient, consent to the performing of whatever procedure may be determined necessary by the Doctor.

I authorize and request the administration of such diagnostic tests, drugs and/or anesthetics as may be deemed advisable by the Doctor. I also understand that upon completion of root canal therapy in this office I will be referred to my dentist for a permanent restoration such as amalgam restoration, onlay, or crown.

I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

YOUR ESTIMATED PORTION IS DUE UPON COMPLETION OF SERVICES

I understand that I am responsible for knowing my insurance plan provisions and limitations and that any information I give will be used to bill my insurance for treatment rendered in the office. I understand that this office may not be a preferred provider with my insurance and I am ultimately responsible for the difference between insurance company fees and doctor's filed fees. I understand a 1% (12% APR) fee will be charged 90 days after initial appointment. Collection charges, attorney fees and court costs, if needed, will be added to my account.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Patient's/Parent's Signature:_____ Date:_____

Last Updated (Date/Initials) _____