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:_____

IF MINOR ❑ Responsible Parent:_____ SSN:_____

Parent Employer:_____Occupation: _____

Parent's Cell:_____Date of Birth: _____

DENTAL INSURANCE INFORMATION

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: _____

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.

Notice of Privacy Practices Acknowledgement

We keep a record of the healthcare services we provide to you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed.

My signature below acknowledges that a copy of this office's Notice of Privacy Practices is available for my review.

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

Last Updated (Date/Initials) _____