PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____ Gender: _____ Date: _____
Last First MI
Birthday; _____ Marital Status: _____SS#:_____Email Add: _____

Phone: (home) _____ (work) _____ext._____ (cell) _____

Address: _____
Street Apt# City State Zip
Employer: _____Phone:_____

Address: _____
Street City State Zip
Whom may we thank for referring you: _____

Please list Current Medications you are taking: _____

Additional Medications You are Taking:_____
_____

Date of Last Dental Visit: _____Reason for Visit: _____

Have you ever had any of the following? Please check YES or NO:

Y N	Y N	Y N	Y N
__ __ AIDS	__ __ Excessive Bleeding	__ __Hypoglycemia	__ __ Sickle Cell Anemia
__ __ Alzheimer's	__ __ Excessive Thirst	__ __ Jaundice	__ __ Sinus Problems
__ __ Anemia	__ __ Fainting	__ __Kidney Disease	__ __ Stomach Problems
__ __ Arthritis	__ __ Fever Blisters	__ __ Liver Disease	__ __ Stroke
__ __ Artificial Joints	__ __ Frequent Cough	__ __Lung Disease	__ __ Swelling of feet/
__ __Artificial Heart Valve	__ __Glaucoma	__ __ Mental Disorders	Ankles/hands
__ __Asthma	__ __Growths	__ __ Mitral Valve Prolapse	__ __ Thyroid Disease
__ __ Blood Disease	Have you ever taken	__ __ Nervous Disorders	__ __ Tuberculosis
__ __ Blood Transfusion	__ __ Phen Phen/Redux	__ __ Pace Maker	__ __ Tumors
__ __ Bruise Easily	__ __ Hay Fever	__ __ Pain in Jaw Joints	__ __ Ulcers
__ __ Cancer	__ __ Head Injuries	__ __ Pregnant	__ __Venereal Disease
__ __ Chemo/Radiation	__ __ Heart Disease	Due Date	__ __ Yellow Jaundice
__ __ Chest Pain/Angina	__ __ Heart Trouble	__ __ Pre Med	__ __ Allergy: Penicillin
__ __ Cold Sores	__ __ Heart Murmur	__ __ Psychiatric Care	__ __ Allergy: Latex
__ __ Cortisone Medicine	__ __ Heart Surgery	__ __ Recent Weight Loss	__ __ Allergy: Sulfa
__ __ Diabetes	__ __ Hemophilia	__ __ Respiratory Problems	__ __ Allergy: Ibuprofen
__ __ Dizziness	__ __ Hepatitis A/B/C	__ __ Rheumatic Fever	__ __ Allergy: Tetracycline
__ __ Drug Addiction	__ __ Herpes	__ __ Rheumatism	__ __ Allergy: Aspirin
__ __ Emphysema	__ __ High Blood Pressure	__ __ Scarlet Fever	__ __ Allergy: Codeine
__ __ Epilepsy or Seizures	__ __ Low Blood Pressure	__ __ Shortness of Breath	__ __ Allergy: Epinephrine
__ __ HIV			Allergies_____

Do you have a specific dental problem?_____ Yes No
Do you have dental examination on a routine basis? Last Visit:_____Yes No
Do you have active decay or gum disease?_____ Yes No
Do you brush/floss on a routine basis? _____ Yes No
Do your gums ever bleed? _____ Yes No
Do you like your smile? _____ _____Yes No
Does food catch between your teeth?_____Yes No
Do you want to keep your remaining teeth?_____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint/Do you brux or grind?_____ Yes No
Have your past experiences in dental office been positive?_____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss_____Yes No
NOTE TO WOMEN: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.
Have you ever had any complications following dental treatment? ____Yes ____No If yes, please explain_____
Have you been admitted to a hospital or needed emergency care during the past two years? ____ Yes ____ No If yes please explain_____
Are you now under the care of a physician/ ____ Yes ____ No If yes please explain_____
Name of Physician_____
Do you have any other health conditions that need further clarification? ____ Yes ____ No If yes, please explain_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health or if my medication changes, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of Patient, Parent or Guardian Date

RESPONSIBLE PARTY INFORMATION

Name: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Other_____

Social Security: #_____Birth Date: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Address: _____Apt:_____City:_____St:_____Zip:_____

In case of emergency whom shall we call: _____?

Relationship: _____Phone No._____

INSURANCE INFORMATION

Subscriber Name: _____ DOB: _____ID or SS #_____

Address: _____Apt:_____City:_____St:_____Zip:_____

Employer Name & Address: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan and Phone: _____

Secondary Insured Person's Info:

Name: _____DOB:_____ID or SS # _____

Address: _____Apt:_____City:_____St:____Zip_____

Employer Name & Address: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan and Phone: _____

CONSENT FOR SERVICES

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services or any dental service performed without prior financial arrangements. Must be paid in cash at the time the services are performed. I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However the dental office cannot render services the assumption that charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental case can only be extended for a period of 6 months from the date of the patient's examination in consideration of the professional services rendered to me or at my request by the Doctor and/or staff. I agree to pay therefore the reasonable value of said services to said Doctor or his assignee at the time said services are rendered or within five days of billing if credit shall be extended I further agree that the reasonable value of said services shall be billed unless objected to by me in writing within the time for payment thereof. Additionally I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys fees.

IT IS OUR POLICY TO CHARGE $80.00 PER HOUR FOR MISSED APPOINTMENTS WITHOUT A 24 HOUR NOTICE. THIS FEE MUST BE PAID PRIOR TO SCHEDULING ANY FUTURE APPOINTMENTS.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit to your account we will need the following authorizations. I have been informed on the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan unless prohibited by law or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges to the extent permitted by law. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims.

_____ _____

Signature of Responsible Party/Guardian Date

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Contemporary Endodontics, PLLC.

_____ _____

Signature of Responsible Party/Guardian Date