

WELCOME TO OUR OFFICE

Patient #
Office Use Only

Please take a few minutes to fill out this form so we may be of better service to you

PATIENT INFORMATION

PLEASE PRINT

Patient Name _____ SS# _____ Birthdate _____

M _____ F _____ Single Married Divorced Widowed Separated

Street Address _____ City _____ Zip Code _____

Home Phone _____ Work phone _____ Cell _____

Spouse's Name _____ Work phone _____ Employer _____

Do you have Dental insurance? Yes _____ No _____ Name of Insurance _____

Policy holder's name _____ Policy holder's employer _____

Policy holder's Birthdate _____

Policy holder's ID# _____ Group # _____

Secondary insurance (if applicable) _____

Secondary insurance card holder name _____ Birthdate _____

Secondary ID# _____ Group# _____

General Dentist name _____

RESPONSIBILITY PARTY INFORMATION FOR MINOR CHILDREN

Name _____ Relationship to patient _____

Street Address _____ City _____ St _____ Zip _____

Home phone # _____ Work # _____ Cell # _____

SS# _____ Birthdate _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
(Name of insurance company)

and assign directly to Northcoast Endodontic Specialists all benefits. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic.

Date _____ Signature _____

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges whether or not paid by insurance. I acknowledge that payment is due at the time of treatment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor child.

Date _____ Signature _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

GENERAL HEALTH

- 1.) How would you describe your general health?
 Excellent Good Fair Poor
- 2.) Have you been seen or been under treatment by your physician in the last year for any reason other than routine physical? Yes No DK
- 3.) Have you been hospitalized in the last five years? Yes No DK
- 4.) Are you taking any medications? If Yes? Please List Yes No DK
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- 5.) Do you have any sensitivity to latex or latex products? Yes No DK
- 6.) Do you take or have you taken oral or I.V. bisphosphonates? (Fosamax, Actonel, Boniva, etc.) Yes No DK
- 7.) Do you take Anticoagulants? (Blood Thinners)? _____ Yes No DK
- 8.) Do you take aspirin on a daily basis? If yes How many? Yes No DK
- 9.) Are you allergic to any medications? If yes Please List. Yes No DK
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- 10.) Are you allergic or have you ever reacted to a local dental anesthetic? Yes No DK
- FOR WOMEN ONLY:
- 11.) Are you pregnant? If yes expected delivery date. _____ Yes No DK
- 12.) Are you taking birth control pills? Yes No

MEDICAL HISTORY

- 1.) Do you have heart problems? Yes No DK
- 2.) High or low blood pressure? If yes? High Low Yes No DK
- 3.) Rheumatic Fever? Yes No DK
- 4.) Lung Problems? (Emphysema, Asthma) Yes No DK
- 5.) Diabetes? Yes No DK
 Hepatitis? Yes No DK
 Jaundice of Liver Disease? Yes No DK
- 6.) Glaucoma? Yes No DK
- 7.) Prolonged Bleeding? Yes No DK
- 8.) Hay Fever? Yes No DK
 Sinus Problems? Yes No DK
- 9.) Epilepsy? Yes No DK
 Seizures? Yes No DK
- 10.) Anemia? Yes No DK
- 11.) Kidney or Bladder Problems? Yes No DK
- 12.) Thyroid Problems or taking Thyroid Medication? Yes No DK
- 13.) Do you have or have you been exposed to the AIDS virus? Yes No DK
- 14.) Cancer or Radiation Therapy? Yes No DK
- 15.) Artificial Joint or Valve Replacement? Yes No DK
- 16.) Is it necessary for you to take antibiotics before having dental treatment due to health conditions? If yes, have you taken your antibiotics today? Yes No DK

Do you have any disease, condition or problem not listed above that you think we should know about or that you believe would affect treatment in any way? Please describe:

Patient's or Guardian's Signature

Date

Endodontist's Signature

Date

Date Reviewed

Date Reviewed

Date Reviewed

THANK YOU