## WELCOME TO OUR OFFICE

**Dr. Mark C. Gorman  Dr. Manuel F. Colaco  Dr. Joseph J. Jurcak  Dr. James B. Flynn**
**Dr. Christopher A. Thompson  Dr. Thomas G. Burke  Dr. Ryan P. Romero  Dr. Ante R. Zovko**

## PATIENT INFORMATION

**PLEASE PRINT**

Patient Name_____SS#_____Birthdate___/_____/_____M_____ F_____

Marital Status____ Home Address_____Apt#_____ City_____ State____ Zip Code_____

Home Phone _____ Work Phone_____ Cell _____

Spouse's Name_____ Emergency Contact_____ Phone_____Relationship_____

Patient e-mail _____ Preferred Contact: call text email (circle) Preferred Phone #_____

General Dentist Name _____ General Dentist Location (CITY)_____

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 # or SSN_____Group #_____

Secondary insurance (if applicable)_____ Employer _____

Secondary insurance card holder name _____ Birthdate_____/_____/_____

Secondary ID #_____Group #_____

## ASSIGNMENT, RELEASE AND FINANCIAL AGREEMENT

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.

●I understand that I am financially responsible for all charges whether or not covered by insurance. I acknowledge that payment is due at the time of treatment. I acknowledge the estimate of insurance coverage is not a guarantee of benefits and my initial payment made at the time of service does not constitute payment in full until the claim has been considered by insurance. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor child.

●I grant permission for Northcoast Endodontic Specialists, Inc. to transfer my protected health information electronically to my general dentist.

List of person(s) to whom I am granting authorization to receive & discuss information regarding my treatment, billing or insurance matters related to my account at Northcoast Endodontic Specialists. This authorization will remain in effect until a new authorization contact is requested. If you need to list additional authorized contacts please ask for an additional form.

Name _____ Relationship_____Name _____ Relationship_____

Name _____ Relationship_____Name _____ Relationship_____

**Signature** _____**Date**_____/_____/_____

## RESPONSIBLE PARTY INFORMATION FOR MINOR CHILDREN

Name_____ Relationship to patient_____ Birthdate_____

SS#_____Home Address_____ City _____ ST _____ Zip_____

Home phone # _____ Work #_____ Cell #_____

**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 □

_____

_____

5.) Do you have any sensitivity to latex or latex products? Yes □ No □ DK □

6.) Are you allergic to any medications? Yes □ No □ DK □
If yes Please List.

_____

_____

7.) Are you allergic or have you ever reacted to a local dental anesthetic? Yes □ No □ DK □

8.) Do you take or have you taken oral or I.V. bisphosphonates? Yes □ No □ DK □
(Fosamax, Actonel, Boniva, etc.)

9. Do you take Anticoagulants? Yes □ No □ DK □
(Blood Thinners)? If yes? Please list: _____

10.) Do you take aspirin on a daily basis? Yes □ No □ DK □
If yes? How many?_____

11.) Do you have sleep apnea? Yes □ No □ DK □
Are you a mouth breather? Yes □ No □ DK □
Do you use a CPAP machine? Yes □ No □ DK □

FOR WOMEN ONLY:
12.) Are you pregnant? If yes Yes □ No □ DK □
expected delivery date. _____
Are you currently breast feeding? Yes □ No □
13.) Are you taking birth control pills? Yes □ No □ DK □

## MEDICAL HISTORY

1.) Do you have heart problems? Yes □ No □ DK □

2.) High or low blood pressure? Yes □ No □ DK □
If yes? High □ Low □

3.) Rheumatic Fever? Yes □ No □ DK □

4.) Lung Problems? Yes □ No □ DK □
(Emphysema, Asthma)

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.) Tuberculosis? Yes □ No □ DK □

15.) Cancer or Radiation Therapy? Yes □ No □ DK □

16.) Artificial Joint or Valve Replacement? Yes □ No □ DK □

17.) Is it necessary for you to take antibiotics before having dental treatment due to health conditions? Yes □ No □ DK □
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**