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. _____ **Patient/Guardian Initials**

●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 HIV? 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