

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

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 _____
General Dentist Name _____ General Dentist Location (CITY) _____
Pharmacy Name _____ Pharmacy Location (CITY) _____ Pharmacy Phone # _____
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
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- 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.
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- 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