Patient Registration and Health History Form

On future visits please be sure to update your medical history.

Patient Information

❑ Mr. ❑ Ms. ❑ Mrs. ❑ Dr. First name _____ M. I. _____ Last name _____

Sex: ❑ M ❑ F Date of birth: / / Social Security #: _____

Occupation / Employer: _____ Height: _____ Weight: _____

Home Address: _____

City: _____State: _____Zip: _____

Phones: Home: _____Business: _____Cell: _____

Email: _____ Pharmacy / Location: _____

General dentist: _____ Referred by: _____
(First and last name) (Please write "same" if referred by General Dentist)

Physician: _____Phone: _____

Emergency Contact

In case of emergency contact: _____ ❑ Spouse ❑ Father ❑ Mother ❑ Other

Phones: Home: _____Business: _____Cell: _____

Reason for Visit

What is the reason for your visit today?_____

How long have you had this problem?_____

What are your symptoms?_____

Allergies

Y N Penicillin, Amoxicillin, Augmentin Y N Aspirin, Advil, Motrin, ibuprofen Y N Sulfa/sulfites Y N Other antibiotics _____	Y N Local anesthetic (novocaine, adrenalin) Y N Valium or other tranquilizers Y N Codeine or other narcotics Y N Latex Other_____

Medical History

Please answer the following questions to the best of your knowledge. Although endodontists primarily treat the mouth area, medical problems or medications could have a significant impact on your dental treatment. Your answers are confidential.

Y N Are you in good health?

Y N Are you under the care of a physician? Date of last physical examination: _____

Y N Have you had any illness, operation, or been hospitalized in the past five years? _____

(PLEASE CONTINUE ON NEXT PAGE)

Y N Prosthetic joint implant _____	Y N Convulsions/epilepsy	Y N Kidney trouble
Y N Heart valve replacement or vascular graft	Y N Parkinson's disease	Y N Are you on dialysis
Y N Damaged heart valves/prosthetic valve	Y N Smoking/chewing tobacco	Y N Bisphosphonates: Fosamax, Acetonel, Aredia, Boniva, Zometa, and Didronel
Y N Heart attack(s)/myocardial infarction (MI)	Y N A history of substance abuse	Y N Arthritis/joint disease
Y N Irregular heart beat/tachycardia	Y N Blood disorder/anemia	Y N Stomach ulcers/GERD
Y N High blood pressure	Y N Bruise easily	Y N Irritable bowel syndrome
Y N Low blood pressure	Y N Blood Thinners: Aspirin, Plavix, Coumadin, Xarelto, Eliquis	Y N Contagious diseases
Y N Chest pain/angina	Y N Abnormal bleeding	Y N Delay in healing
Y N Mitral valve prolapse/heart murmur	Y N Eye disease/glaucoma	Y N Tumor/ growth
Y N Rheumatic Fever/Rheumatic Heart Disease	Y N Hepatitis/jaundice/liver disease	Y N Radiation/chemotherapy/cancer
Y N Cardiac pacemaker	Y N HIV/AIDS/STD	Y N Are you on a diet
Y N Heart surgery/bypass surgery	Y N Infectious mononucleosis	Y N Immune system problems
Y N Stroke/Transient Ischemic Attack (TIA)	Y N Gallbladder trouble	Y N Malignant hyperthermia
Y N Respiratory problems	Y N Fainting spells	Y N Chronic fatigue
Y N Bronchitis/chronic cough	Y N Thyroid trouble	Y N Mental health problems
Y N Asthma	Y N Diabetes / Low blood sugar	
Y N COPD / Emphysema	Y N Swollen ankles	Other _____
Y N Tuberculosis		

Medications

Please list all medications you are currently taking: _____

_____

_____

Women

Y N Are you pregnant? If yes, estimated delivery date: _____

Y N Is there a possibility of pregnancy?

Y N Are you nursing?

Y N Are you taking birth control pills? (Antibiotics may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control if antibiotics are prescribed.)

I certify that I have read and I understand the questions in the Patient Registration and Health History form. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my endodontist, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I understand that I am responsible for notifying my endodontist of any medical changes upon each visit.

Patient Signature: X _____ **Date: X** _____
(Parent or Guardian if minor)

Authorization

I authorize my endodontist and his/her staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. If medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Patient Signature: X _____ **Date: X** _____
(Parent or Guardian if minor)

Acknowledgement of Receipt of Notice of Privacy Practices

Edgewater Endodontics, LLC will use and disclose your personal health information to treat you and to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution. You may refuse to sign this acknowledgement.

Patient Signature: X _____ **Date: X** _____
(Parent or Guardian if minor)

Doctor: X _____

FINANCIAL POLICY and PATIENT BILLING

Patients WITHOUT Dental Insurance

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance, and understanding of our financial policy.

Payment for services is due at the time services are rendered, unless other arrangements have been made in advance. For your convenience we accept Visa, MasterCard, Discover, American Express and Care Credit. Returned checks and balances older than 30 days may be subject to a financial charge of 1.5% per month.

If you have questions regarding your account, please feel free to ask your appointment coordinator or assistant before your consultation.

Patient Signature _____

Patients WITH Dental Insurance

We are committed to providing you with the best possible care. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and understanding of our financial policy.

Edgewater Endodontics will file all claims and paperwork with your insurance carrier, however payment for services is due at the time services are rendered [including copayment or coinsurance], unless other arrangements have been made in advance. For your convenience we accept Visa, MasterCard, Discover, American Express and Care Credit. Returned checks and balances older than 30 days may be subject to a financial charge of 1.5% per month.

If you have questions regarding your account, please feel free to ask your appointment coordinator or assistant before your consultation.

Assignment of Benefits

I hereby authorize and direct payment of dental benefits to Edgewater Endodontics on my behalf for any services furnished to me by the providers. However, I understand that due to frequency limitations by insurance carriers, Edgewater Endodontics collects, and I will be responsible for any fee(s) associated with my consultation [including radiographs and/or CBCT imaging].

Edgewater Endodontics will file the appropriate paperwork with my insurance carrier; however the insurance carrier will decide on reimbursement.

Patient Signature _____

Medical Information Release Form

Name: _____ Date of Birth: _____ / _____ / _____

I authorize the release of information including diagnosis, records, appointments, and information related to examinations performed to me, and any claims/insurance information. This information may be released to:

[ ] Information is NOT to be released to anyone besides myself and my general dentist.

[ ] My spouse: _____

[ ] Other: _____

This authorization will remain in effect until terminated by me in writing.

Signature: _____ Date: _____ / _____ / _____