ENDODONTIC SPECIALISTS, P.C.

PATIENT INFORMATION (PLEASE PRINT)

FIRST NAME - INITIAL - LAST NAME	BIRTHDATE	AGE	SOCIAL SECURITY #	MARITAL STATUS

ADDRESS	CITY	STATE	ZIP

AREA CODE/HOME PHONE	AREA CODE/WORK PHONE	AREA CODE/CELL PHONE	EMAIL ADDRESS

MALE ☐ FEMALE ☐	OCCUPATION/STUDENT	EMPLOYER/SCHOOL

GENERAL DENTIST NAME	REFERRING PERSON OR DENTISTS NAME	PHYSICIANS NAME - PHYSICIANS PHONE #

HEALTH INFORMATION

ARE YOU IN GOOD HEALTH? ☐ YES ☐ NO **WOMEN:** BIRTH CONTROL PILLS? ☐ YES ☐ NO

ARE YOU UNDER PHYSICIANS CARE? (Not routine) ☐ YES ☐ NO ARE YOU PREGNANT? ☐ YES ☐ NO What month? _____

ARE YOU SUBJECT TO PROLONGED BLEEDING? ☐ YES ☐ NO ARE YOU NURSING? ☐ YES ☐ NO

CIRCLE ANY OF THE FOLLOWING YOU ARE ALLERGIC OR HAVE HAD A REACTION TO

PENICILLIN	LOCAL ANESTHETIC	ASPIRIN	NITROUS OXIDE
SULFA	NOVOCAIN	CODEINE	VALIUM
ERYTHROMYCIN	TETRACYCLINE	IBUPROFEN	LATEX
OTHERS (PLEASE SPECIFY)			

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING INCLUDING NON-PRESCRIPTION DRUGS & MEDICATIONS

HAVE YOU TAKEN ANY PAIN MEDICATION IN THE PAST 24 HRS? (Over the counter also) ☐ YES ☐ NO If yes please list above

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING. (GIVE DATE IF POSSIBLE)

HEART TROUBLE	PROSTHETIC JOINTS	AIDS/ARC/HIV	PSYCHIATRIC TREATMENT
MITRAL VALVE PROLAPSE	DIABETES	IV DRUG USE	HAY FEVER/ALLERGIES
OSTEOPOROSIS	HEPATITIS	VENEREAL DISEASE	EPILEPSY
HEART VALVE REPLACEMENT	GLAUCOMA	TRANSFUSION	RADIATION/CHEMOTHERAPY
HIGH BLOOD PRESSURE	ANEMIA	CHEMICAL DEPENDENCE	TUBERCULOSIS
STROKE	SORE JAW (TMJ)	ASTHMA	FAINTING SPELLS
BLOOD DISORDER	BITE SPLINT	RESPIRATORY DISEASE	KIDNEY TROUBLE

ADDITIONAL INFORMATION

DO YOU HAVE A MEDICAL CONDITION NOT LISTED ABOVE? ☐ YES ☐ NO

IF YES PLEASE EXPLAIN _____

IS THIS TREATMENT THE RESULT OF AN INJURY? ☐ YES ☐ NO

FINANCIAL POLICY

We are committed to providing you with the best possible endodontic care. We also want to serve you in a manner which is as comfortable and pleasant as possible. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly discuss your treatment, giving you as accurate an estimate as possible and answering any questions that we can about your dental insurance.

We want you to understand that the extent of your insurance benefits is defined in a contract between you, your employer and an insurance company. We are not a party to that contract. As your endodontic care providers, our relationship is only with you, not your insurance company. The filing of insurance claims is a courtesy that we extend to our patients, however all charges are ultimately your responsibility. We will help you by submitting your insurance claim form. Full payment of your portion is due at the time of treatment. We accept cash, check, Mastercard and VISA.

Our most common fees are:

An exam, diagnosis & records fee will be charged to all patients $90 -$180
Anterior $760 Bicuspid $860 Molar $990 Surgery $990-$1190
Emergency treatment $330
An additional fee of $150 - $300 may be added for retreatment of a previous root canal.
Please speak to our receptionist prior to treatment if you are unable to pay your portion.

A time-price differential (a late fee for professional services) of 1.5% per month may be imposed on all patient balances owing more than 30 days. By signing below you acknowledge that you understand the information above and you agree to be responsible for payment of all costs, including any collection fees.

I UNDERSTAND THAT UPON COMPLETION OF THE ROOT CANAL, I NEED TO *RETURN* TO MY GENERAL DENTIST FOR PERMANENT RESTORATION OF THE TREATED TOOTH. I AFFIRM THAT ALL OF THE INFORMATION ON THIS FORM IS ACCURATE.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN OF PATIENT **DATE**

DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO
IF YOU HAVE DENTAL INSURANCE, PLEASE FILL OUT THE FOLLOWING:

YOUR FIRST DENTAL INSURANCE

DENTAL INSURANCE NAME: _____ GROUP #: _____
NAME OF POLICY HOLDER: _____ BIRTHDATE: _____
POLICY HOLDER'S ID# (USUALLY SS#): _____
EMPLOYER: _____

YOUR SECOND DENTAL INSURANCE

DENTAL INSURANCE NAME: _____ GROUP #: _____
NAME OF POLICY HOLDER: _____ BIRTHDATE: _____
POLICY HOLDER'S ID# (USUALLY SS#): _____
EMPLOYER: _____

(OFFICE USE)
ELIG _____
AMAX _____
BENYR _____
RMAX _____
INIT/DATE _____

ELIG _____
AMAX _____
BENYR _____
RMAX _____
INIT/DATE _____

WE WILL ATTEMPT TO *ESTIMATE* YOUR BENEFITS AND FILE YOUR CLAIM IF YOU HAVE PROVIDED US WITH ALL THE NECESSARY INFORMATION. SOME INSURANCE COMPANIES DO NOT COVER ALL PROCEDURES OR THEY MAY COVER LESS THAN WE ESTIMATED. A STATEMENT FOR THE BALANCE WILL BE SENT TO YOU IF THIS OCCURS. YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT IN FULL OF YOUR ACCOUNT. BY SIGNING BELOW I AUTHORIZE ENDODONTIC SPECIALISTS, P.C. TO RELEASE INFORMATION TO MY INSURANCE COMPANY REGARDING MY TREATMENT.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN OF PATIENT **DATE**