ENDODONTIC SPECIALISTS, P.C.

PATIENT INFORMATION (PLEASE PRINT)

MR. ☐ MS. ☐ MRS. ☐	FIRST NAME - INITIAL - LAST NAME	BIRTHDATE	AGE	SOCIAL SECURITY #

ADDRESS	CITY	STATE	ZIP

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

MALE ☐ FEMALE ☐	OCCUPATION/STUDENT	EMPLOYER/SCHOOL

GENERAL DENTIST NAME	REFERRING PERSON OR DENTISTS NAME	PREFERRED PHARMACY

HEALTH INFORMATION

WOMEN: BIRTH CONTROL PILLS? ☐ YES ☐ NO PREGNANT? ☐ YES ☐ NO What month? _____ NURSING? ☐ YES ☐ NO

ALL PATIENTS: ARE YOU SUBJECT TO PROLONGED BLEEDING? ☐ YES ☐ NO

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

PENICILLIN/AMOXICILLIN	CLINDAMYCIN	ASPIRIN	LATEX
SULFA	STEROIDS	CODEINE	DENTAL ANESTHETIC
ERYTHROMYCIN	TETRACYCLINE	IBUPROFEN	
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	JOINT REPLACEMENT WHEN?_____		PSYCHIATRIC TREATMENT
MITRAL VALVE PROLAPSE	DIABETES	AIDS/HIV	EPILEPSY
HEART VALVE REPLACEMENT	OSTEOPOROSIS	GASTRIC BYPASS SURGERY	RADIATION/CHEMOTHERAPY
HIGH BLOOD PRESSURE	HEPATITIS	TRANSFUSION	TUBERCULOSIS
STROKE	GLAUCOMA	SUBSTANCE ABUSE	FAINTING SPELLS
BLOOD DISORDER	SORE JAW (TMJ)	RESPIRATORY DISEASE	KIDNEY TROUBLE
BITE SPLINT			

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, all major credit cards and Care Credit.

Our most common fees are:

An exam, diagnosis & imaging fee will be charged to all patients $124-$299

Anterior $795 Bicuspid $910 Molar $1061 Surgery $1218-$1320

Anterior retreatment $985 Bicuspid retreatment $1093 Molar retreatment $1265

If root canal treatment is initiated but unable to be completed, a reduced fee will be billed.

Please speak to our receptionist prior to treatment if you are unable to pay your portion.

By signing below that you acknowledge and you agree you understand the information above to be responsible for payment of all costs, including any collection fees.

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 _____

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.

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**