

ACCOUNT NUMBER: _____

DOCTOR NUMBER: _____

HEALTH HISTORY AND REGISTRATION FORM FOR ENDODONTIC ASSOCIATES, INC.
PATIENT INFORMATION (PLEASE PRINT)

FIRST NAME: _____ MI: _____ LAST NAME: _____ GENDER: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONES: HOME(____) _____ MOBILE(____) _____ WORK(____) _____ OCCUPATION: _____

EMPLOYER NAME & ADDRESS: _____

SOC.SEC.# _____ Have you been a patient of ours before today? _____ Spouse: _____

Nearest relative or friend (NOT LIVING WITH PATIENT): _____

General Dentist: _____

IF PATIENT IS UNDER 18 YEARS OLD

MOTHERS INFORMATION

NAME: _____ BIRTHDATE: _____

ADDRESS: _____

CITY, STATE & ZIP: _____

MOBILE PHONE: _____

SS#: _____ HOME PHONE: _____

EMPLOYER: _____ WK PHONE: _____

FATHERS INFORMATION

NAME: _____ BIRTHDATE: _____

ADDRESS: _____

CITY, STATE & ZIP: _____

MOBILE PHONE: _____

SS#: _____ HOME PHONE: _____

EMPLOYER: _____ WK PHONE: _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Co.: _____ Group #: _____

Address: _____

City, State & Zip: _____

Phone #(____) _____ Employer: _____

Employees Name: _____ Birthdate: _____

SS#: _____ ID#: _____

SECONDARY INSURANCE

Insurance Co.: _____ Group #: _____

Address: _____

City, State & Zip: _____

Phone #(____) _____ Employer: _____

Employees Name: _____ Birthdate: _____

SS#: _____ ID#: _____

ACCIDENT

This treatment due to an accident _____ If yes - when(DATE) _____ where _____

Details of the Accident _____

HEALTH HISTORY

1.) Are you in good health? Yes No

2.) Are you under the care of a physician? Yes No

3.) Are you taking birth control pills?*** Yes No

4.) Do you bleed excessively or heal slowly? Yes No

5.) Are you pregnant? Yes No

6.) Are you allergic to any drugs? Yes No

****IF YES-ANY ANTIBIOTIC(i.e. penicillin, cephalexin etc.) will reduce the effectiveness of the birth control pill**

List Drug Allergies: _____

HAVE YOU HAD ANY OF THE FOLLOWING? IF YES CIRCLE: Rheumatic Fever Tuberculosis Allergies Headaches Hepatitis

Artificial joints Earaches Epilepsy Venereal Disease Diabetes AIDS(HIV) Facial Muscle Pain Kidney Disease

Heart Disease Other: _____

RECENT MEDICATION: _____

TREATMENT AUTHORIZATION AND CONSENT FORM

I understand Root Canal Treatment is a procedure to retain a tooth which would otherwise need extraction. Although Root Canal Therapy has a very high degree of clinical success it is a biological procedure and as such cannot be guaranteed. Long-term success depends upon the individual's response to treatment, the infection's (when present) response to treatment and medication and to the influences such as restoration of the tooth, periodontal (gum) condition and biting habits.

I also understand that only the root canal treatment is to be performed at this office and that the permanent restoration (filling, crown, etc) will be done by my regular dentist. I also understand that the dentists performing the treatment in this office are specialists in this field. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full at or before completion, unless specific arrangements are made with the office manager. A minimum service charge of 1.75% will be added each month if full payment is not received within 60 days of completion of the treatment.

I authorize the release of any medical information necessary to process claims and to consult with my appropriate medical provider if necessary concerning my medical status. I authorize payment of medical benefits to ENDODONTIC ASSOCIATES, INC. for services rendered. I agree, in the event that my bill goes unpaid for over 60 days, that I will be responsible for the balance and that I will also be liable to pay all reasonable collection costs, including court cost and reasonable attorney fees.

SIGNED: _____ DATE: _____