NAME/MS.
MISS/MR.
MRS./DR. ____ SS# _______--______--_________
LAST MI FIRST

DATE ______/______/______

ADDRESS____ DATE OF BIRTH _____/_____/______
STREET CITY/TOWN ZIP

HOME PHONE ( )______________________ CELL ( )_____________________ E-MAIL________________________________

OCCUPATION_____________________________PLACE OF WORK__________________________________ WORK PHONE ( )_________________

REFERRING DENTIST____
NAME CITY/TOWN

CONTACT IN CASE OF EMERGENCY____ RELATIONSHIP__________ PHONE( )_______________

REASON FOR THIS VISIT ____

CHECK IF YOU HAD BEEN CARED FOR BY ANY OF THE FOLLOWING:

☐ ORTHODONTIST ☐ PERIODONTIST ☐ ORAL SURGEON ☐ OTHER NAME ___________________________________

PHYSICIAN'S NAME____ PHONE ( ) ______________________

ARE YOU NOW OR HAVE YOU RECENTLY BEEN UNDER A PHYICIAN'S CARE? Y / N

IF YES, FOR WHAT REASON ____

CHECK IF YOU ARE ON ANY OF THE FOLLOWING MEDICATION:

☐ STEROID ☐ SYNTHROID ☐ COUMADIN ☐ PLAVIX ☐ ASPIRIN

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, IF ANY ____

____

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

☐ DIABETES	☐ CONGENITAL HEART DEFECT	☐ HERPES
☐ ALLERGIES	☐ RHEUMATIC FEVER	☐ HIV
☐ ASTHMA / HAY FEVER	☐ HEART MURMUR	☐ STROKE
☐ SINUS PROBLEM	☐ MITRAL VALVE PROLAPSE	☐ DIZZY SPELLS / SEIZURES
☐ EAR INFECTION	☐ ARTIFICIAL VALVE	☐ EPILEPSY
☐ TUBERCULOSIS	☐ PACE MAKER	☐ NEUROLOGICAL DISORDER
☐ LUNG DISEASE	☐ IRREGULAR HEARTBEAT	☐ GLAUCOMA
☐ PNEUMONIA	☐ HEART ATTACK WHEN ________	☐ DRUG OR ALCOHOL ADDICTION
☐ LIVER DISEASE	☐ HEART SURGERY	☐ PSYCHIATRIC TREATMENT
☐ HEPATITIS / JAUNDICE	☐ ABNORMAL BLEEDING	☐ CANCER ______________________
☐ SLOW HEALING	☐ HIGH BLOOD PRESSURE	☐ CHEMOTHERAPY
☐ KIDNEY DISEASE	☐ LOW BLOOD PRESSURE	☐ RADIATION THERAPY
☐ STOMACH ULCERS	☐ ANEMIA	☐ MAJOR OPERATION ________________
☐ THYROID DISEASE	☐ ARTHRITIS	☐ PROSTHETIC JOINTS WHEN ___________

☐ OTHER ____

CHECK IF YOU HAVE HAD SENSITIVITY OR ALLERGIC RESPONSE TO ANY OF THE FOLLOWING:

☐ LOCAL ANESTHETICS ☐ EPINEPHRINE ☐ ASPIRIN ☐ CODEINE ☐ LATEX ☐ IODINE ☐ ANTIBIOTICS ______________________

☐ OTHERS ____

HAVE YOU EVER TAKEN ANTIBIOTICS BEFORE DENTAL PROCEDURES? Y / N NAME _____________________________________

DO YOU SMOKE TOBACCO? Y / N IF YES, HOW MUCH? ____

WOMEN ONLY: ARE YOU PREGNANT? Y / N HOW MANY MONTHS? ___________ ARE YOU BREAST FEEDING? Y / N

PLEASE INDICATE ANY SPECIAL CONCERNS RELATED TO YOUR DENTAL TREATMENT ______________________________

____

I HAVE REVIEWED THE INFORMATION ON THIS QUESTIONNAIRE AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

____/______________________________DATE ___/____/______
SIGNATURE OF PATIENT OR PARENT IF PATIENT IS A MINOR OR RESPONSIBLE PARTY RELATIONSHIP TO PATIENT

Endodontics

60 Washington Avenue, Hamden, CT 06518
Phone (203) 281-6574 FAX (203) 281-1045

PATIENT BILLING AND DENTAL INSURANCE INFORMATION

Financially Responsible Party (Name)_____________________________________ SS#____/____/____

Patient (Print Name) ____ SS#_____/_____/____

Financially Responsible Party (Address) ____

City State Zip

DENTAL INSURANCE COMPANY INFORMATION (**If you do not have dental insurance to cover endodontic services, please proceed to the AUTHORIZATIONS AND FINANCIAL AGREEMENT)**

Name of the Dental Insurance Company: ____

Address: ____

City State Zip

Subscriber Name (Print) ____

a. Date of Birth (MM/DD/CCYY) ____ /____/____

b. Address ____

City State Zip

c. Subscriber Identifier (SSN or ID#) ______________________________________

d. Plan / Group Number ____

e. Employer Name ____

Employer Address____

City State Zip

Patient's Relationship to Primary Subscriber (Please Circle Below)

Self Spouse Dependent Child Other (Explain) _______________________

AUTHORIZATIONS

I authorize insurance payments be made directly to the doctor for services rendered and understand that I am financially responsible for charges regardless of insurance coverage. To the extent permitted by law, I consent to the release of protected medical information to third parties as specified by HIPAA laws regarding Privacy Practices for the purpose of enabling the doctor to obtain payment for dental services rendered. I understand that if the third party is not a health care provider the released information may no longer be protected. I understand that I may revoke this authorization at any time and that it will automatically terminate one year from the date the dental services have been completed.

Patient's or Guardian's Signature: ____ Date___/___/____

Financially Responsible Party's Signature ___________________________________ Date____/___/____

FINANCIAL AGREEMENT

I agree that I am financially responsible for all services rendered by the doctor regardless of insurance coverage. Payment in full is due at the time dental services are rendered, unless other payment arrangements have been approved in writing in advance by our staff. I agree that all balances 30 days past due (after all insurance claims are processed) are subject to late charges at the rate of $10.00 per month. I agree to pay reasonable attorney's fees as limited by law and all costs of collection in case of default on payment of the account. **I hereby certify that I have read and understand this form, and have received a copy of this document.**

Financially Responsible Party's Signature _____________________________________ Date___/____/____