ENDODONTIC SPECIALISTS, PA Practice Limited to Endodontics

Medical History

Address Dentist City/State/Zip Physician Physician Date of Last Physical Date of Birth Date of B	Name Who Referred Yo	Who Referred You			
Prone: (Home) (Business) Date of Last Physical	Address Dentist	Dentist			
Cell # Social Security # Date of Birth	City/State/Zip Physician				
Occupation & Employer Marital Status Do you have dental insurance? If yes, name of company PRESENT HEALTH (PLEASE SPECIFY WHERE APPROPRIATE) Yes No 0 1 1 1 1 1 1 1 1	Phone: (Home) (Business) Date of Last Phys	Date of Last Physical			
PRESENT HEALTH (PLEASE SPECIFY WHERE APPROPRIATE) 1. Are you in good health? 2. Are you under a physician's care now? If so, please specify reasons for treatment. 3. Are you taking any kind of medication at the present time? If so, please specify 4. Do you take a daily aspirin or any other blood thinner? 5. Please circle any illnesses you have ever had: ALERGIES TUBERCULOSIS ANEMA HEART TROUBLE RHEUMATICE FEVER BELEPSY GLAUCOMA HEART MURMUR OTHER 6. Do you have a family history of Diabetes? FILEPSY GLAUCOMA HEART MURMUR OTHER 6. Do you have a family history of Diabetes? PLAY YOU have a family history of Diabetes? PLAY YOU have a family history of Diabetes? PLAY YOU have a family nursual or allergic reaction to any anesthetic or drug? PLAY YOU allergic to penicillin? PLAY YOU allergic to latex? PLAY YOU allergic to late	(Cell #)Social Security # Date of Birth				
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Remarks

ENDODONTIC SPECIALISTS, PA ****INSURANCE RELEASE****

PATIENT'S NAME:
Please present your Dental Insurance card(s). List below all your dental insurance companies
Primary Dental Insurance Company:
EMPLOYEES NAME:
RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD
EMPLOYEES SOCIAL SECURITY NO: ID#
EMPLOYEES NAME: RELATIONSHIP TO PATIENT: SELFSPOUSECHILD EMPLOYEES SOCIAL SECURITY NO: ID#_ EMPLOYEE'S DATE OF BIRTH: _ / _ / _ Group#
Second Dental Insurance Company:
EMPLOYEES NAME:
RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD
EMPLOYEES SOCIAL SECURITY NO: ID#
EMPLOYEES NAME: RELATIONSHIP TO PATIENT: SELFSPOUSECHILD EMPLOYEES SOCIAL SECURITY NO: ID#_ EMPLOYEE'S DATE OF BIRTH: _ / _ / _ Group#
In consideration of dental treatment to be rendered to me or my dependents, I agree to sign over
every dental benefit payment issued to me for dental services performed by this office within ten
business days after receipt from a Dental Service Corporation, Health Service Corporation or
Dental Plan Organization provided, however, if the amount owed to this office is less than the
amount of the dental benefit payment, then only the balance owed shall be paid.
We are NOT providers of any DMO, HMO or any other managed care. You are responsible for
our fee regardless of your Insurance. This may include any benefits that could be denied or
any remaining balances that aren't paid by your Insurance.
business that aren't part by your insurance.
Signature
I hereby authorize the release of any information necessary to my insurance company. I understand this may include a report and or x-rays. If assignment of benefits is allowed by my insurance company. I will hereby authorize payment to be made to Endodontic Specialists.
Signature
****PAYMENT METHODS****
All payments and co-pays are expected when services are rendered. We accept Visa, Master Card, Discover, American Express, Care Credit, Cash or Personal Check.
There is a \$30.00 fee for returned checks.
A STATEMENT FEE OF \$3.00 WILL BE CHARGED PER MONTH UNTIL YOUR ACCOUNT IS PAID IN FULL.
Signature