ENDODONTIC SPECIALISTS, PA
Practice Limited to Endodontics

Medical History

Name _____ Who Referred You _____

Address _____ Dentist _____

City/State/Zip _____ Physician _____

Phone: *(Home)*_____ *(Business)*_____ Date of Last Physical _____

*(Cell #)*_____ Social Security # _____ Date of Birth _____

Occupation & Employer _____ Marital Status _____

Do you have dental insurance? If yes, name of company _____

PRESENT HEALTH (PLEASE SPECIFY WHERE APPROPRIATE)

*U – Unknown

	Yes	No	U	
1. Are you in good health?	❑	❑	❑	1.
2. Are you under a physician's care now?	❑	❑	❑	2.
If so, please specify reasons for treatment_____				
_____				
3. Are you taking any kind of medication at the present time? If so, please specify_____	❑	❑	❑	3.
_____	❑	❑	❑	4.
_____ *(Please include Aspirin, Vitamins, Birth Control Pills, etc.)*				
4. Do you take a daily aspirin or any other blood thinner?				
5. Please circle any illnesses you have ever had:	❑	❑	❑	5.

ALLERGIES TUBERCULOSIS ANEMIA HEART TROUBLE
RHEUMATIC FEVER DIABETES EPILEPSY GLAUCOMA
HEPATITIS KIDNEY OR LIVER ASTHMA HEART MURMUR
OTHER_____

6. Do you have a family history of Diabetes?	❑	❑	❑	6.
7. Have you ever had trouble with prolonged bleeding after surgery or extractions of a tooth?	❑	❑	❑	7.
8. Have you ever had any unusual or allergic reaction to any anesthetic or drug?	❑	❑	❑	8.
9. Are you allergic to penicillin?	❑	❑	❑	9.
10. Are you allergic to latex?	❑	❑	❑	10.
11. Are you pregnant? *(Women only)*	❑	❑	❑	11.
12. Have you been tested for A.I.D.S.?	❑	❑	❑	12.
If so, were you H.I.V. positive or H.I.V. negative_____				
13. Is there any other information that should be known about your health or your previous dental visits? *(Please Specify)* _____	❑	❑	❑	13.
_____				

Signature _____ Date_____
(If Minor, Parent's Signature)

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#***_____
EMPLOYEE's DATE OF BIRTH: _ _/_ _ /_ _ Group#_____

Second Dental Insurance Company: _____

EMPLOYEES NAME:_____
RELATIONSHIP TO PATIENT: SELF_____SPOUSE_____CHILD_____
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.**

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_____