PERSONAL HISTORY

ENDODONTICS, P. A.

7939 Honeygo Blvd. • Suite 227
White Marsh Professional Center
Baltimore, MD 21236
(410) 931-0250 • Fax (410) 931-4876

DATE

PATIENT'S NAME (PLEASE PRINT)

ADDRESS

CITY

STATE ZIP

MARITAL STATUS: ❒ SINGLE ❒ MARRIED ❒ WIDOWED ❒ SEPARATED ❒ DIVORCED

SEX: ❒ MALE ❒ FEMALE

PATIENT'S AGE DATE OF BIRTH

HOME PHONE NO. WORK PHONE NO.

SOC. SECURITY NO.

DRIVER'S LIC. NO.

PATIENT'S OCCUPATION

PATIENT'S EMPLOYER

EMPLOYER'S ADDRESS

REFERRED BY DR.

Have you ever been treated in our office before? ❒ YES ❒ NO

IF SO, WHEN?

IN CASE OF EMERGENCY, NOTIFY

PHONE NO. RELATIONSHIP

FINANCIALLY RESPONSIBLE PERSON IF OTHER THAN PATIENT

NAME (FIRST, M.I., LAST)

ADDRESS

CITY

STATE ZIP

SEX: ❒ MALE ❒ FEMALE

DATE OF BIRTH SOCIAL SECURITY NO.

HOME PHONE NO. WORK PHONE NO.

OCCUPATION

EMPLOYER

ADDRESS

CITY

ST ZIP

If patient is over 18 years of age and is a full time student:

NAME OF SCHOOL

CITY

CHART NO.

DOCTOR

REF. DOCTOR

Please complete both sides of this form.

PRIMARY DENTAL INSURANCE

NAME OF INSURANCE CO.

PHONE NO.

ADDRESS

CITY ST ZIP

ID/AGREEMENT NO. GROUP NAME OR NO.

SUBSCRIBER'S NAME ON INSURANCE COVERAGE (if different from patient)

DATE OF BIRTH SOCIAL SECURITY NO.

EMPLOYER'S NAME

ADDRESS

HOW IS PATIENT RELATED TO THE SUBSCRIBER?
❒ SPOUSE ❒ DEPENDENT

DATE

SECONDARY DENTAL INSURANCE

NAME OF INSURANCE CO.

PHONE NO.

ADDRESS

CITY ST ZIP

ID/AGREEMENT NO. GROUP NAME OR NO.

SUBSCRIBER'S NAME ON INSURANCE COVERAGE (if different from patient)

DATE OF BIRTH SOCIAL SECURITY NO.

EMPLOYER'S NAME

ADDRESS

HOW IS PATIENT RELATED TO THE SUBSCRIBER?
❒ SPOUSE ❒ DEPENDENT

What percentage will this Insurance Co. cover? _____ %

Signature

Fill out information to the left ONLY if you have dental insurance

OVER ➢

PATIENT'S NAME (please print) _____

1. General Health:
❒ Excellent ❒ Good ❒ Fair ❒ Poor

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

If yes, please explain: _____

3. Name and address of family physician:

4. Are you wearing a pacemaker or heart valve prosthesis? ❒ Yes ❒ No

5. Have you been hospitalized or had a serious illness in the past five years? ❒ Yes ❒ No

If yes, please explain: _____

6. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?
❒ Yes ❒ No

7. Are you taking *any* kind of medication (prescribed or non-prescribed) or drug at this time?
❒ Yes ❒ No

If yes, please explain: _____

8. Are you pregnant? ❒ Yes ❒ No

If yes, how many months? _____

9. Have you ever undergone Endodontic Treatment? ❒ Yes ❒ No

Check any of the following to which you're allergic or have had an unusual reaction to:

❒ Penicillin	❒ Aspirin	❒ Demerol
❒ Sulfa Drugs	❒ Darvon	❒ Nitrous Oxide
❒ Erythromycin	❒ Codeine	❒ Steroids
❒ Novacaine (Xylocaine)	❒ Valium (tranquilizers)	❒ Ibuprofen
❒ Sedatives & Barbituates	❒ Latex	❒ Nickel
❒ Other _____		

Check any of the following which you have had:

❒ HIV+	❒ Sinus Trouble	❒ Glaucoma
❒ Hepatitis	❒ Anemia	❒ Thyroid Trouble
❒ Heart Trouble	❒ Asthma	❒ Fainting Spells
❒ Heart Murmur	❒ Cough	❒ Venereal Disease
❒ Rheumatic Fever	❒ Hay Fever	❒ Herpes
❒ High Blood Pressure	❒ Hives or Skin Rash	❒ Arthritis
❒ Angina	❒ Diabetes	❒ Kidney Trouble
❒ Stroke	❒ Tuberculosis	❒ Radiation Therapy
❒ Congenital Heart Disease	❒ Epilepsy	❒ Psychiatric treatment
❒ Ulcers or Lung Disease	❒ Migraine	

Is there anything else about your health we should know? _____

What is your chief dental complaint? _____

Signature _____ Date _____

ENDODONTICS, P.A
FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dental insurance, we are glad to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our Financial Policy with regard to payments for services rendered.

Payment for service is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept Cash, Personal checks, Visa, MasterCard, and Discover credit cards for your convenience. Those patients with both primary and secondary insurance coverage should discuss payment arrangements with our staff at the time of their initial office visit.

We are happy to discuss your proposed treatment and answer any questions related to your insurance. We must emphasize that as a dental care provider, **OUR RELATIONSHIP IS WITH YOU NOT WITH YOUR INSURANCE COMPANY.** Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. **All charges are your responsibility from the date the services are rendered.**

It is extremely important for your dental health that you keep all of your scheduled appointment(s). Each appointment slot is reserved for you and you alone. Should it become necessary for you to reschedule your appointment, **WE REQUIRE 24 HOURS NOTICE.** To assist you in contacting us, We provide a 24-hour answering service. ***THERE WILL BE A $50 FEE CHARGED FOR ANY APPOINTMENT CANCELLED OR BROKEN WITHIN 24 HOURS.***

Patients whose checks are returned will be charged a $30 service fee.

HMO/PPO Patients: If you have dental coverage through a HMO or PPO, We will handle your claims according to our agreement with your particular insurance company. You are responsible for the co-payments as indicated by your scheduled plan. Your co-payment must be received prior to completion of your treatment.

INITIALS_____

PRIVATELY INSURED PATIENTS: If you have private dental insurance, you are required to pay 40% of the total fee before the completion of your treatment. You need to be aware that not all insurance companies will cover the remainder of the entire fee. After our staff submits the necessary forms and receives payment from your insurance company, we will bill you for any balance due. This balance is your responsibility and must be paid within 7 business days. If the amount collected exceeds the balance due, we will promptly reimburse you. Initial office visit fees for consultation and/or diagnostic services are relatively nominal and we are unable to bill your insurance company directly. Therefore, patients with private insurance who receive only these services are required to pay-in-full at the time of the visit. Our staff will complete the insurance claim form for you to submit and any benefits owed to you will be mailed to you directly.

INITIALS_____

NON-INSURED PATIENTS: If you do not have dental insurance, you are expected to pay the total fee by the time treatment is completed.

INITIALS_____

FINANCIAL POLICY AGREEMENT:
My initials above and signature below indicate that I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. ***FAILURE TO PAY FOR ENDODONTIC SERVICES WITHIN 30 DAYS WILL INCUR A 1.5% FINANCE CHARGE, AS WELL AS ANY ATTORNEY FEES AND COURT COSTS.*** I have read all the information above and have completed the registration and health history form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or in the registration information.

_____ Date_____
Signature