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, PA
Financial Policy

Thank you for choosing our office as your endodontic healthcare provider. We are committed to providing you with the highest quality endodontic dental care so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment. Please read the following information and initial and sign in the appropriate sections.

Initials

_____ **Payment**

- Payment (insurance co-pay or full fee) is due at the time services are provided. We do not bill.
- We accept cash, personal checks, and the following credit cards: Visa, Mastercard, and Discover.
- A $30 service fee will be applied to all returned checks.
- A 1.5% monthly finance charge will be applied to all outstanding balances after 60 days.

_____ **Insurance**

- As a courtesy to our insured patients we will verify your dental insurance coverage prior to your appointment and determine a co-pay **estimate** that is due at the time of service. Please be aware: This is only an **estimated co-pay**, and is subject to the limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums as determined by your insurance company at the time the claim is processed. We cannot guarantee payment by your carrier, and it is ultimately your responsibility to be familiar with the benefits and exclusions of your insurance plan.
- Our office will submit all claims to your insurance carrier in a timely manner. Insurance claims are typically processed within 30-60 days; however, there are times when claim processing may take longer. We will work to resolve any issues with your insurance company to the best of our ability. Issues that cannot be resolved after 90 days will become the responsibility of the patient. We must stress – our relationship is with you, our patient, and not your insurance company.
- All charges incurred are your responsibility, regardless of your insurance coverage.

_____ **Missed appointment and cancellations**

- It is extremely important for your dental health that you keep all scheduled appointments.
- We require at least 24-hour notice for cancellations/rescheduling. To assist you, we provide a 24-hour answering service.
- A $40 service charge will be applied for any appointment no-shows or same-day cancellations.

_____ **Communication**

- By signing below, you are authorizing us to contact you and leave a message regarding insurance issues and account balances on any phone number/email address provided by you.

_____ **Minors accompanied by a parent/legal guardian**

- All patients under the age of 18 must be accompanied by a parent/legal guardian. The parent/legal guardian accompanying a minor, who consented to treatment and signed all paperwork, is responsible for payment and is required to stay for the duration of the appointment.

Financial Policy Agreement: My initials above and my signature below indicate that I read, understand, and agree that I am ultimately responsible for the balance on my account regardless of insurance status for any services rendered. Failure to pay for endodontic services within 60 days will incur a 1.5% finance charge, as well as any attorney fees, court costs, and certified mail charges incurred while recouping the balance.

Signature: _____ **Date:** _____