Welcome to Our Office!

GULF COAST ENDODONTICS
Getting to the ROOT of the Problem

Date:_____

Patient Information:

Please circle: Ms. Mr. Mrs. Dr. Other _____

_____ _____ _____ _____
LAST NAME FIRST NAME MI NAME PREFERENCE

Address:_____ Apt#_____ City:_____State:____Zip:_____
(IF P.O. BOX GIVE STREET ADDRESS ALSO)

Home #:_____Work #:_____ Cell #:_____ Email:_____

Social Security Number:_____-_____-_____ Date of Birth:_____ Sex: ☐ M ☐ F Spouse's Name:_____

Your Employer:_____Employer's Address:_____

General Dentist:_____ Physician:_____ Referred By: _____

Is the patient a full-time student? ☐ No ☐ Yes Name of School_____

In case of emergency contact: Name:_____Work Number:_____Home Number:_____

MEDICAL HISTORY: Please check Y for "yes" or N for "no" for any of the following which may apply to you now or in the past:

Y N	Y N	Y N	Y N	Y N
☐ ☐ Artificial Heart Valve	☐ ☐ Tuberculosis	☐ ☐ High Blood Pressure	☐ ☐ Diabetes	☐ ☐ Drug Addiction
☐ ☐ Rheumatic Fever	☐ ☐ Hepatitis A, B or C	☐ ☐ Heart Murmur	☐ ☐ Thyroid Condition	☐ ☐ Pain in Jaw Joints
☐ ☐ Mitral Valve Prolapse	☐ ☐ HIV Positive	☐ ☐ Heart Surgery	☐ ☐ Angina Pectoris	☐ ☐ Bleeding Disorders
☐ ☐ Congenital Heart Lesions	☐ ☐ Heart Disease or Attack	☐ ☐ Heart Pacemaker	☐ ☐ Artificial Joint	☐ ☐ Epilepsy or Seizures

Have you ever taken Bisphosphonates? _____ (i.e. Fosamax, Aredia, Zometa, Actonel, Boniva, Skelid, Didronel, Bonefos Ostec)

Any other diseases or problems? _____

Have you ever had an unusual reaction to latex, anesthetics, or drugs such as Penicillin, Erythromycin, Novacaine, Codeine, Aspirin, Sulfa, or any other medications?

If yes, Please explain: _____

What Medications are you taking at present?_____

Have you taken Aspirin or Ibuprofen in the last 72 hours? ☐ Yes ☐ No; If yes: ☐ AspirinIbuprofen;Howmany?_____

Women: Are you pregnant? ☐ Yes ☐ No; If yes,what month? _____

THE PURPOSE of endodontic treatment or root canal treatment is to save the tooth rather than remove it. Although treatment has a high degree of success, it can not be guaranteed. Occasionally, a tooth that has had a root canal treatment may require re-treatment, surgery or even extraction.

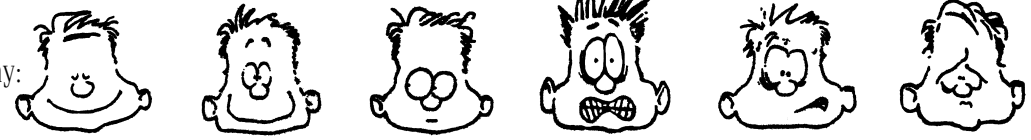
Treatment is usually a non-surgical procedure, but in some cases, a surgical approach is necessary. Before any treatment is begun the reason(s) will be explained, including alternative modes of therapy. Occasionally, pre-medication may be indicated. This will be discussed in advance.

PLEASE NOTE: The fee will not include a permanent filling or crown on the tooth. You must return to your general dentist to have that treatment completed.

I consent to necessary treatment and authorize the release of any information needed for continued treatment.

X_____ _____
SIGNATURE OF PATIENT (CUSTODIAL PARENT/GUARDIAN OF MINOR) DATE

PLEASE: How are you feeling today:



☐ Confident ☐ Happy ☐ Curious ☐ Frightened ☐ Anxious ☐ Pained

Please continue to the reverse side and complete.

If the following applies, please fill out completely. We will need a copy of your Dental Insurance card.

PRIMARY DENTAL INSURANCE:

Name of Insured Person (Employee):_____Relationship to Patient:_____

Member ID#:_____-_____-_____ Date of Birth:_____

Employer/Retired From:_____ Length of Employment:_____

Name of Insurance Company:_____Group#_____ Phone:_____

Address:_____City:_____State:_____ Zip:_____

SECONDARY DENTAL INSURANCE:

Name of Insured Person (Employee):_____Relationship to Patient:_____

Member ID#:_____-_____-_____ Date of Birth:_____ Employer/Retired From:_____

Name of Insurance Company:_____Group#_____ Phone:_____

Address:_____City:_____State:_____ Zip:_____

I hereby authorize the provider to file my insurance and benefits to be paid directly to the provider.
I also understand that when my particular insurance is filed:

1. I authorize the release of any information related to my claim to my insurance company.

2. I am ultimately responsible for the balance on my account for any professional services rendered regardless of the amount my insurance pays toward my account. We ask that patients with insurance pay estimated portion of the cost of treatment; at the time service is received.

3. Any balance not paid by my insurance will be due within two weeks of the statement date, a **LATE FEE** and/or a **SIMPLE INTEREST CHARGE** may be added to the account. The **INTEREST CHARGE** will be a periodic rate of **1.5 %** per month, which is an **ANNUAL PERCENTAGE RATE** of **18%** applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

If patient is under the age of 18 years old, please complete the following:

Responsible Party:_____ Date of Birth: _____ Social Security:_____

Address:_____City:_____State:_____Zip:_____

Home #:_____Work #:_____ Relationship to Patient:_____

I HAVE/DO NOT HAVE (please circle one) dental insurance. I am financially responsible for fees incurred at the time of service.

X_____ _____

SIGNATURE OF PATIENT (CUSTODIAL PARENT/GUARDIAN OF MINOR) DATE

For Office Use Only: Copy of insurance card provided: Yes_____ No_____ Initials_____