PATIENT REGISTRATION

Name (Mr., Ms., Miss, Mrs., Dr.)_____

Home Address_____

City_____ State_____ Zip Code_____

Phone_____ Cell_____ Married ❒ Single ❒

Birthdate_____ Social Security No._____

Employer_____ Business Phone_____

Emergency Contact Phone No._____

Name of Spouse or Parent (if minor)_____

Spouse Social Security No._____ Spouse Birthday_____

Spouse Employer_____ Business Phone_____

Name of Physician(s)_____

Name of Referring Dentist_____

Name of General Dentist (if different)_____

Is dental treatment partially covered by insurance? Yes ❒ No ❒

Name of Company?_____

Party responsible for account_____

HEALTH HISTORY

	YES	NO
Have you ever had artificial replacements? (knee, hip, heart valve, other)	❒	❒
Have you ever had any transplants? (heart, liver or kidney)	❒	❒
Describe_____		
Have you ever had heart, lung, liver or kidney problems?	❒	❒
Describe_____		
Do you require any premedication for Dental Appointments?	❒	❒

• **Circle any of the following diseases or conditions that you have had.**

Heart Attack	Fainting	Jaundice
High Blood Pressure	Ulcers	Hepatitis
Rheumatic Fever	Diabetes	Tuberculosis
Stroke	Glaucoma	Venereal Disease
Heart Murmur	Asthma	HIV Positive
Bleeding Problems	Sinus Trouble	AIDS
		Other:_____

• Women: Are you Pregnant or Nursing? ❒ Yes ❒ No

• Are you allergic or have any adverse reaction to any of the following drugs?

	YES	NO		YES	NO
Penicillin	❒	❒	Aspirin	❒	❒
Codeine	❒	❒	Tylenol	❒	❒
Novocaine (Local Anesthetics)	❒	❒	Other Drugs_____		

• What was your allergic reaction?_____

Over

• Have you ever been hospitalized for a serious illness? ❒ Yes ❒ No

• Have you ever had any problems during dental treatment? ❒ Yes ❒ No

_____

_____

• List Medications taken during the past year.

_____

_____

CONSENT

I understand Root Canal Therapy is a procedure to retain a tooth which may otherwise require extraction. Occasionally, a patient may experience postoperative discomfort or swelling which will require medication for several days. Although Root Canal Therapy has a very high degree of clinical success, it is still a biological procedure so it cannot be guaranteed.

Occasionally, a tooth which has had Root Canal Therapy may require Retreatment, surgery, or even extraction. Generally, specialist treat difficult teeth. Therefore, complications may occur during treatment that may effect the longevity of the tooth, (i.e. perforation, broken instruments, overfills or underfills). However, every effort will be made to successfully treat your tooth.

I also understand that ONLY the Root Canal Therapy is to be performed at this office. The permanent restoration, (filling, onlay, crown, etc.) will be done by my general dentist.

Patient / Parent's Signature_____

Date_____

FINANCIAL POLICY

Cash, Check VISA or MasterCard may be used at the time services are rendered.

YOU ARE FULLY RESPONSIBLE FOR YOUR ACCOUNT.

INSURANCE: Since most insurance claims pay 80% for Root Canal Therapy we require payment of your estimated portion of 20% of fees upon treatment completion. We are glad to help you file claims. However it is not our obligation to collect payments from your insurance company. Disputes of coverage, benefits, etc. are strictly between you and your insurance company.

NO INSURANCE: We require payment of 50% of total bill upon completion of treatment. The other 50% is due within the next 30 days.

PAYMENT AGREEMENT TERMS: _____

_____

Each Month you will be sent a statement for the current balance. Payment on that statement is due in full within 30 days.

Accounts which receive no payments for 90 days will be placed with an attorney for collection and listed with the credit bureau. In the event of default, the undersigned agrees to pay collection and attorney fees.

By my signature, I certify I understand the above and agree to abide by the same.

Date:_____

Signature:_____