Rochester Endodontics, PA

Please Print

Date _____

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name _____ (First / M.I. / Last) Nickname _____

Gender ☐ Male ☐ Female Birth Date _____ Email _____

Street _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Employer _____ City _____ State _____

General Dentist _____ Referring Dentist _____

Physician _____ Clinic _____ Phone (_____)_____

Emergency Contact Name _____ Relationship to Patient _____ Phone (_____)_____

Account Responsibility (If patient is under age 18.)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name _____ (First / M.I. / Last) Nickname _____

Relationship to patient ☐ Mother ☐ Father ☐ Step Mother ☐ Step Father ☐ Legal Guardian ☐ Foster Parent ☐ Other _____

Gender ☐ Male ☐ Female Birth Date _____ Email _____

Street _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Employer _____ City _____ State _____

Primary Dental Insurance Company

Name Ins Co _____

Group # _____ Group Name _____

Policy Holder's Information:

Full Name _____ DOB _____ M F

Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Phone (_____)_____

SS# _____ ID # _____

Insurance Plan is Through:

Employer / Union Name _____

Secondary Dental Insurance Company

Name Ins Co _____

Group # _____ Group Name _____

Policy Holder's Information:

Full Name _____ DOB _____ M F

Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Phone (_____)_____

SS# _____ ID # _____

Insurance Plan is Through:

Employer / Union Name _____

Acknowledgements and Authorizations (Please read each line below.)

Without Insurance: Full payment is expected at time of service. Other arrangements can be made with our office manager depending upon special circumstances. Should your account become delinquent, you will be responsible for all collection costs, attorney's fees, and court costs.

With Insurance: Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Please complete the identifying information on this form.

- In-Network Plans: It is your responsibility to pay all estimated out-of-pocket fees at time of treatment. Please ask us if we are in-network with your dental insurance plan.
- Out-of-Network Plans: It is your responsibility to pay all fees at time of treatment.

I authorize the release of information necessary to process my claim(s). I hereby authorize to the doctor named of the benefits otherwise payable to me.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

I certify that I have read and I understand the above. I affirm that the information contained in the form and any additional information that I may furnish is true and correct to the best of my knowledge.

Signature _____ Relationship to Patient _____ Date _____

Rochester Endodontics, PA

Health History

Date: _____

Patient Name: _____ Birth Date: _____

Date Last Saw Medical Physician: _____ Reason for that visit: _____

Please answer each question:

Yes	No	
☐	☐	Are you under the care of a physician?
☐	☐	Have you ever been hospitalized for any surgical operation or serious illness? If yes, describe _____ _____
☐	☐	Are you taking any medications, non-prescription medications, herbal medicines, vitamins? Please list _____ _____ _____ _____ _____
☐	☐	Does your medical doctor currently require you to take antibiotics (pre-medication) prior to dental appointments for a heart murmur, prosthetic joint, or cancer?
☐	☐	Are you taking any phosphodiesterase inhibitor (erectile/sexual dysfunction) medication?
☐	☐	Do you use tobacco?

Yes	No	
☐	☐	Do you wear contact lenses?
☐	☐	Do you have any history of anesthesia complications?
☐	☐	Do you have a blood relative with any history of anesthesia complications?
☐	☐	Have you ever taken bisphosphonate medication for your bones or cancer? (i.e. Fosamax, Boniva, etc…)
☐	☐	Is there anything you would like to discuss with the doctor alone?

Are you allergic to or have you had any reaction to the following?

☐	☐	Local Anesthetics
☐	☐	Antibiotics _____
☐	☐	Sulfa drugs
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Latex
☐	☐	Other _____

Do you now have, or have you had any of the following?

Yes	No	Respiratory/Lungs
☐	☐	Recent Cold / Cough
☐	☐	Pneumonia / Flu
☐	☐	Asthma / Bronchitis
☐	☐	Emphysema
☐	☐	Short of Breath / Easily Winded
☐	☐	Tuberculosis Date:_____
☐	☐	Sleep Apnea
☐	☐	Other _____

Liver / Kidneys

☐	☐	Kidney Disease
☐	☐	Hepatitis / Jaundice
☐	☐	Liver Disease
☐	☐	Other _____

Neurological

☐	☐	Fainting
☐	☐	Epilepsy / Convulsions /Seizures
☐	☐	Psychiatric Treatment / Anxiety / Depression / Other
☐	☐	Stroke / Transient Ischemic Attack
☐	☐	Cognitive Deficiencies
☐	☐	Vertigo
☐	☐	Other _____

Yes	No	Cardiovascular
☐	☐	Mitral Valve Prolapse
☐	☐	Rheumatic Fever
☐	☐	High / Low Blood Pressure
☐	☐	High Cholesterol
☐	☐	Abnormal Rhythm
☐	☐	Peripheral Vascular Disease
☐	☐	Blood Clots
☐	☐	Leukemia or Anemia
☐	☐	Blood Transfusion
☐	☐	Bleeding disorder
☐	☐	Heart Disease
☐	☐	Congestive Heart Failure
☐	☐	Swollen Ankles
☐	☐	Cardiac Pacemaker / AICD
☐	☐	Heart Murmur
☐	☐	Congenital Heart Lesions
☐	☐	Heart Attack Date _____
☐	☐	Angina / Chest Pain
☐	☐	Heart Valve Replacement
☐	☐	Cardiac Stent
☐	☐	Other _____

Yes	No	Musculoskeletal
☐	☐	Arthritis / Back or Hip Problem
☐	☐	Joint Replacement / Implant year_____
☐	☐	Muscle Weakness / Paralysis
☐	☐	Numbness / Tingling
☐	☐	Other _____

Other

☐	☐	Diabetes
☐	☐	AIDS / HIV / STD
☐	☐	Frequently Tired
☐	☐	Thyroid Disease
☐	☐	Cancer
☐	☐	Stomach Trouble / Nausea
☐	☐	Hiatal Hernia
☐	☐	Gastric Reflux
☐	☐	Hay Fever / Seasonal Allergies
☐	☐	Radiation Therapy
☐	☐	Glaucoma
☐	☐	Recent Weight Loss / Gain
☐	☐	Cold Sores
☐	☐	Other _____

Yes	No	
☐	☐	**Are you <u>now using</u> or have you <u>ever used</u> drugs such as:** Cocaine, heroin, methamphetamine, marijuana, or others? *These drugs may interact with medications prescribed or used in this office.*

Women Only:

Yes	No	
☐	☐	Are you pregnant?
☐	☐	Do you think you may be pregnant?
☐	☐	Are you nursing?
☐	☐	Are you taking Birth Control Pills?

I certify that I have read and I understand the above. I affirm that the information contained in the form and any additional information that I may furnish is true and correct to the best of my knowledge.

_____

Patient Signature Date