Piedmont Endodontics, LLC

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date_____ Patient's Name_____
Last First Middle

Responsible Person (if patient is a minor)_____
Last First Middle

Address_____ City_____ State_____ Zip_____

Home Ph# (___)_____ Work Ph# (___)_____ Cell Ph# (___)_____

Soc. Sec. #_____ Email_____

Sex ☐ M ☐ F Age_____ Birthdate_____

Patient Employed by_____ Occupation _____

Business Address_____

Whom may we thank for referring you?_____

In an emergency who should be notified?_____Relationship to you_____ Phone(___)_____

PRIMARY DENTAL INSURANCE

Subscriber _____
Last Name First Name Middle Date of Birth

Relation to Patient _____ Soc. Sec. #_____

Address (If different from patient's)_____ Phone (___)_____

City_____ State_____ Zip_____

Insurance Company _____Group#_____Phone (_____)_____

Insurance Co. Address_____ID#_____

Is patient covered by additional dental insurance? ☐ Yes ☐ No

Person Responsible for Account _____

I give consent for electronic correspondence from this office ___YES ____ NO

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices
(HIPAA information packet available upon request)

Print name:_____**Signature:**_____**Date:**_____

Patient refuses to sign HIPAA: Staff initial_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Are you currently under physician's care? ☐ Yes ☐ No If yes, why _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Do you need to pre-medicate with antibiotics for dental treatment? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Taking birth control pills/Hormone Therapy? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High/Low Blood Pressure	☐ Stroke
☐ Artificial Heart Valves	☐ Emphysema	☐ HIV/AIDS/ARC	☐ Thyroid Problems
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain TMJ/TMD	☐ Tobacco Habit
☐ Asthma	☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Tonsillitis
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Tuberculosis
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Ulcer
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Venereal Disease
☐ Chemical Dependency	☐ Heart Problems	☐ Radiation Treatment	☐ Atrial Fibrillation
☐ Chemotherapy	☐ Hemophilia	☐ Respiratory Disease	☐ Other
☐ Circulatory Problems		☐ Rheumatic Fever	_____

Over the Counter and RX MEDICATIONS
you are currently taking:

_____

_____

ALLERGIES
☐ **Latex** ☐ **Medications (list below)**

_____

Patient Consent

I, the undersigned, consent to the performing of an endodontic exam and endodontic procedures that may be desired, necessary, or advisable after reviewing treatment options with the doctor. I have provided an accurate and complete medical and personal history including all current medications and allergies. **I also understand that I am to promptly return to my dentist for a permanent restoration of the treated teeth**.

Patient (Guardian) Signature_____ **Date:**_____

AUTHORIZATION AND FINANCIAL POLICY

Please read, initial each line, and sign below

I understand the office ***does not*** offer a payment plan but does accept Cash/Check, VISA, MC, AMEX, DISC and Care Credit. Initial____

I understand all dental insurances are considered **Out of Network** with Piedmont Endodontics and as a courtesy, the office will submit the claim electronically. However, all fees are payable by me at the time of service. Initial_____

I authorize the dentist to release all information necessary to secure the payment of benefits. Initial_____

It is my responsibility to understand how my insurance policy pays for services rendered. Initial_____

The office does not file any Medicaid, Medicare and or Workman's Compensation Claims. Initial_____

Signature_____ **Date** _____