Access Endodontics, LLC
Practice Limited to Endodontics

Mr. Mrs. Ms. Dr.	Last Name	First Name & MI	Birth Date	Social Security No.
Address	Apt #	City / State / Zip	E Mail Address	Employer
Home Phone		Cell Phone	EMERGENCY Contact Name	EMERGENCY Contact Phone

General Dentist/Referring Office: _____

Payment is due at the time of service as follows:
Insured Patients: Insurance benefits are estimated prior to appointment and are not guarenteed. We collect your "estimated" out of pocket.
Uninsured Patients: We collect in full at the time of service.

☐ Please check this box if you are a Medicare Beneficiary

PRIMARY DENTAL INSURANCE			SECONDARY DENTAL INSURANCE		
Policy Holder (IF NOT PATIENT) Relationship to patient: self spouse mother father			Policy Holder Relationship to patient: self spouse mother father		
Address (if different from above)			Address (if different from above)		
City / State /Zip			City / State / Zip		
Home Phone	Cell Phone	Birth Date	Home Phone	Cell Phone	Birth Date
Social Security Number			Social Security Number		
EMPLOYER			EMPLOYER		
PRIMARY DENTAL INSURANCE			SECONDARY INSURANCE COMPANY		
INS. ADDRESS			INS. ADDRESS		
GROUP OR LOCAL #			GROUP OR LOCAL #		
SUBSCRIBER / MEMBER ID #			SUBSCRIBER / MEMBER ID #		

Your insurance policy is a contract between you and your insurance company. You are responsible for payment to Access Endodontics, LLC, regardless of any insurance company's arbitrary determination of usual and customary rates. Payment is due at the time of service.

I hereby request and authorize my insurance company to pay directly to Access Endodontics, LLC, insurance benefits for services rendered. I also understand and agree that **any unpaid balance** not covered by my insurance benefits is my obligation and will be paid by me within the guidelines of Access Endodontics, LLC, policy.

I authorize the release of any information pertaining to my claim to the insurance company and direct payment to Access Endodontics.

PATIENT or PARENT/GUARDIAN SIGNATURE _____ DATE _____

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Written Financial Policy

Thank you for choosing Access Endodontics. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, American Express®, Visa®, MasterCard® or Discover Card®
- CareCredit[1]
    - Allows you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Access Endodontics requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2] Insurance benefits are **estimated** prior to appointment and not guaranteed. Access Endodontics charges $35.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____
Print Patient Name

_____
Signature (patient, parent or guardian) Date

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

MEDICAL HISTORY

PATIENT NAME_____ Birth Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? Yes No If yes, please explain:_____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:_____
Have you ever had a serious head or neck injury? Yes No If yes, please explain:_____
Are you taking any medications, vitamins or supplements? Yes No If yes, please list on next page.
Do you take, or have you taken, Phen-Fen or Redux? Yes No
Do you use controlled substances? Yes No
Are you on a special diet? Yes No
Do you use tobacco? Yes No

Have you been instructed by a physician to pre-medicate with antibiotics prior to dental appointments (i.e. joint replacement or heart condition)? Yes No If yes, please explain what for:_____
Did you take your pre-medication today? Yes No N/A
Have you ever been diagnosed with cancer? Yes No If yes, what type?:_____
If yes, what medications/treatments did you receive? _____
Have you been given any injections/medications to strengthen your bones? Yes No If yes, please explain:_____
Have you been given any bisphosphonate medications, such as Reclast? Yes No If yes, please explain:_____

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Local Anesthetics

Other:_____ If yes, please explain:_____

Do you have or have you had:

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Recent Weight Loss	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Renal Dialysis	Yes	No
Anaphylaxis	Yes	No	If diabetic, most recent A1C_____			Hepatitis B or C	Yes	No	Rheumatic Fever	Yes	No
Anemia	Yes	No	Drug Addiction	Yes	No	High Blood Pressure	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Easily Winded	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Emphysema	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Epilepsy or Seizures	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Bleeding	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Excessive Thirst	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Autoimmune Disease	Yes	No	Fainting Spells/Dizziness	Yes	No	Lymphoma	Yes	No	Swelling of Limbs	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Liver Disease	Yes	No	Thyroid Disease	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Low Blood Pressure	Yes	No	Tonsillitis	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Lung Disease	Yes	No	Tuberculosis	Yes	No
Bruise Easily	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tumors or Growths	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Osteoporosis	Yes	No	Ulcers	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Pain in Jaw Joints	Yes	No	Yellow Jaundice	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Parathyroid Disease	Yes	No			
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Psychiatric Care	Yes	No			
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Radiation Treatments	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain:_____

Women: Are you pregnant/trying to get pregnant? Yes No Taking oral contraceptives: Yes No Nursing? Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE_____

FOR STAFF USE ONLY

Blood Pressure:_____ Pulse:_____

Comments:_____

_____

_____

OVER→

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MEDICATION & ALLERGY INFORMATION

Please list all medications, supplements and vitamins you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

☐ **NONE**

Please list all known allergies (including dyes, medications and/or environmental):

_____

_____

_____

_____

_____

☐ **NO KNOWN ALLERGIES**

_____
Print Patient Name

_____
Signature (patient, parent or guardian) Date

Access Endodontics, LLC
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Receipt of Acknowledgement

Notice of Health and Privacy Practices

I hereby acknowledge the receipt of Access Endodontics, LLC Notice of Health Information Privacy Practices.

_____
Print Patient Name

_____
Signature (patient, parent or guardian) Date