



**Access Endodontics, LLC**  
Practice Limited to Endodontics

|                           |           |                 |                    |                        |
|---------------------------|-----------|-----------------|--------------------|------------------------|
| Mr.<br>Mrs.<br>Ms.<br>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 guaranteed. 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**

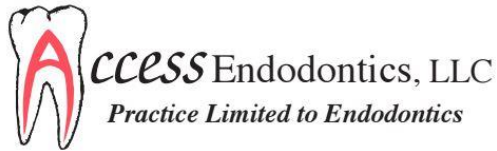
|  |            |            |  |            |            |
|--|------------|------------|--|------------|------------|
| Policy Holder (IF NOT PATIENT)                     |            |            | Policy Holder                                      |            |            |
| Relationship to patient: self spouse mother father |            |            | 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   |            |            |
| <b>PRIMARY DENTAL INSURANCE</b>                    |            |            | <b>SECONDARY INSURANCE COMPANY</b>                 |            |            |
| 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** \_\_\_\_\_



## 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<sup>1</sup>
  - 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.<sup>2</sup> 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

<sup>1</sup>Subject to credit approval

<sup>2</sup>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 \_\_\_\_\_

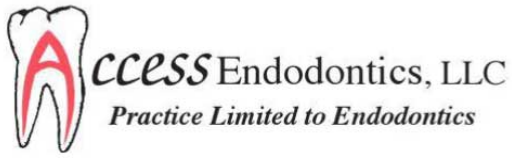
## FOR STAFF USE ONLY

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## 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

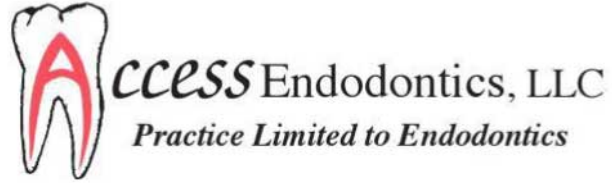
---

Print Patient Name

---

Signature (patient, parent or guardian)

Date



**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