RESPONSIBLE PARTY INFORMATION

Name _____ _____
LAST FIRST MIDDLE MARITAL STATUS

Residence _____
STREET CITY STATE ZIP

Mailing Address _____
(IF DIFFERENT THAN RESIDENCE) STREET CITY STATE ZIP

How long at this address _____ Home Phone _____ Best Phone _____

Previous address _____
(IF LESS THAN 3 YEARS) STREET CITY STATE ZIP

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
LAST FIRST MIDDLE

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Whom may we thank for referring you to our office? _____

PATIENT INFORMATION (if under 18)

Patient Name _____ Birthdate _____

EMERGENCY INFORMATION

Name _____ Phone _____ Relationship _____

METHOD OF PAYMENT

Fees must be paid in full at the time of treatment.

❑ Cash ❑ Check ❑ Visa ❑ MC ❑ Discover ❑ Care Credit

All information written is true and complete. Signature: _____ Date _____

If dental insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is the liability of the responsible party. You understand any estimation of benefits and patient portion is not a guarantee of payment. All claims are subject to review by your insurance company. Initials _____

Updates: (Date & Initial) _____ _____ _____ _____ _____

ADMINISTRATIVE USE ONLY

Primary Ins. Co. _____ Insured's Name _____

DOB _____ ID# _____ Group No. _____ Relationship _____

Secondary Ins. Co. _____ Insured's Name _____

DOB _____ ID# _____ Group No. _____ Relationship _____

MEDICAL HISTORY

Please complete the following questions in order that we may thoroughly diagnose your condition.

The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

	YES	NO
1. Has there been any change in your general health within the past year?	❑	❑
Please specify: _____		
2. Are you under the care of a physician for a current problem?	❑	❑
Reason: _____		
3. Have you been hospitalized within the past five years?	❑	❑
Reason: _____		
4. Are you taking any medications or drugs?	❑	❑
Please specify: _____		
5. Have you received therapy for alcoholism or drug addiction during the past five years?	❑	❑
6. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to anesthetics, latex, antibiotics, or other medications?	❑	❑
Please specify: _____		
7. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?	❑	❑
8. Have you ever required a blood transfusion?	❑	❑
Please explain: _____		
9. Have you ever had surgery and/or radiation for a tumor, growth or other condition?	❑	❑
Please explain: _____		
10. Have you ever been tested for HIV infection (AIDS)?	❑	❑
Result of test: Date: _____ ❑ Positive ❑ Negative		
11. Date of last physical exam. _____		

12. Do you have or have you had any of the following (please check):

- ❑ High blood pressure
- ❑ Heart murmur of prolapsed valve (MVP)
- ❑ Joint prosthesis; specify _____
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Congenital heart disease
- ❑ Cardiovascular disease: heart attack, stroke, by-pass
- ❑ Prosthetic heart valve
- ❑ Blood disorder (e.g., anemia)
- ❑ Venereal disease
- ❑ Asthma; carry inhaler _____
- ❑ Temporomandibular joint problems (TMJ)
- ❑ Cancer; specify _____
- ❑ Sinus trouble
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Stomach ulcers, colitis
- ❑ Jaundice or liver disease
- ❑ Hepatitis; Type_____
- ❑ Kidney problems
- ❑ Psychiatric treatment
- ❑ Fainting spells or seizures (circle)
- ❑ Epilepsy

	YES	NO
13. Do you have any disease, condition, or problem not listed above?	❑	❑
Please specify: _____		
14. Are you required to premedicate with antibiotics or an oral sedative prior to dental treatment?	❑	❑

WOMEN:

15. Are you pregnant? If yes, estimated due date: _____	❑	❑
16. Are you nursing?	❑	❑
17. Do you take birth control pills?	❑	❑
If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.		

All of the above information is true and complete.

PERMISSION FOR ROOT CANAL TREATMENT - I, the undersigned, consent to the performing of any dental procedure of the tooth which may be decided upon to be necessary or advisable in the opinion of the doctor. I understand my other option is extraction. I also understand that only the root canal treatment is to be done at this office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be completed by my regular dentist.

Date_____ Signature of Patient*_____

*All signatures must be by parent or guardian if patient is under the age of 18.

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Lakewood Endodontics. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Lakewood Endodontics reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ YES	☐ NO
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	☐ YES	☐ NO
Any Member of my extended family: (i.e. Parents, Grandchildren)	☐ YES	☐ NO
Other:	☐ YES	☐ NO
Name of patient (please print):		
Patient signature:		
Patient's personal representative: (Please Print):		
Personal Rep's signature:		
Representative's Phone Number:	**Date:**	

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ YES	☐ NO	**Date Statement Provided:** _____
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	