Asheville Endodontics

Patient's Name: _____Date of Birth: _____/_____/_____
LAST FIRST MI

What do you prefer to be called: _____ MALE FEMALE SS #: _____-_____-_____

Home Address: _____City: _____Home Phone: (____)_____

State: _____ Zip: _____ Drivers License #: _____ Cell Phone: (____)_____

Employer: _____ Occupation: _____ Business Phone: (____)_____

Emergency Contact: _____ Relation: _____ Phone #: (____)_____

Referred By: _____ General Dentist: _____

Primary Dental Insurance: _____ Address: _____

Policy Holders Name: _____Address (if different than patients)_____

Relation: _____ Date of Birth: ____/_____/____Insured's Employer: _____

Insured's SS/ID #: _____ Group #: _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.
Initials I fully understand I am solely responsible for any balance not paid by my insurance company (if offered in this office).

Consent for Treatment

I, the undersigned, being the patient, parent or guardian consent to the performing of procedures decided upon to be necessary or advisable in this office, I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown or permanent filling within ***no more than four weeks*** of endodontic treatment.
I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure and cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

_____ _____
Signature Date

Office Payment Policy

I am confirming that I have read and understand the financial policy of this office and that I am agreeing to fulfill my financial obligation today to this office.

_____ _____
Signature Date
___Adult patient ___Parent or Guardian ___Spouse

I have read a copy of the Notice of Privacy Practices for the above named practice.
Copy is provided upon request

_____ _____
Signature Date

Please complete Medical History on back side

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MEDICAL HISTORY

Have you ever taken: Bisphosphonates (ex. Actonel/Fosamax) ___Yes ___NO or Phen-fen/Redux ___YES ___NO

Do you have or have you had any of the following diseases, medical conditions or procedures? (Please check if yes)

___Heart Attack/Stroke
___Heart Surgery/Pacemaker
___Heart Murmur
___Rheumatic Fever
___Mitral Valve Prolapse
___Artificial Valves
___Heart Disease
___Congenital Heart Defect
___Chest Pains
___Nervousness
___Tuberculosis TB
___Thyroid Problems
___Kidney Problems
___Liver Problems
___Respiratory Problems
___Sinus Problems
___Stomach Problems/Ulcers
___Psychiatric Problems
___Scarlet Fever
___Venereal Disease
___Alcohol/Drug Abuse
___Jaw Problems TMJ/TMD
___Cancer/Tumors
___Hepatitis
___HIV+/AIDS/ARC
___Arthritis/Rheumatism
___Artificial Bones/Joints
___Emphysema
___Fainting/Seizures/Epilepsy
___Severe/Frequent Headaches
___Frequent Neck Pain
___Back Problems
___Asthma
___Difficulty Breathing
___Diabetes/Hypoglycemia
___Anemia
___High/Low Blood Pressure
___Bleeding Problems
___Blood Transfusion
___Anticoagulants
___Steroid

Please list any other surgeries or medical conditions you have ever had: _____

_____

Are you taking any medications? If yes, please list: _____

_____

Are you allergic to any of the following? __Latex __Penicillin/Amoxicillin __Sulfa __Aspirin __Dental Anesthetics

Others (please list) _____

Women: Are you pregnant? __N __Y/How long? _____ Are you nursing? __No __Yes Birth control pills? __No __Yes

Do you use tobacco? __No __Yes/How used? _____ How much? _____ How Long? _____

Are you under the care of a physician? __N __Y If so, Physician's name and why _____

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient

- *I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.*

Signature _____ ***Date*** ____/____/____

___Adult patient ___Parent or Guardian ___Spouse