Welcome to Central Iowa Endodontics

PATIENT INFORMATION: **DATE:** ___________

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name ______________________________ M.I. ____ Last Name ____________________________________

Sex: ☐ Male ☐ Female Birth Date ________________ Age _____ Social Security Number ____

Street ____ City _______________________________ State _____ Zip ___________

Home Tel: (_____) ____________________ Cell: (_____) ____________________ Have you ever been a patient of our practice? ☐ Yes ☐ No

Dentist ______________________________ Medical Doctor _________________________ Referred By ___________________________________

Driver's Lic. # _________________________ Nearest relative not living with you _______________________Tel:(_____)__________________

Employer___________________________ Bus. Tel: (_____) ____________________ Personal Payment Type: ☐ Cash ☐ Check ☐ Credit Card

In case of emergency, please contact ____________________________________ Tel: (_____) ____________________ Relation ________________

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other ____

Name ________________________________ S.S.# _________________ Birth Date ______________ Age ____Tel:(_____)____________________

Street ____ City ____________________________ State ______ Zip ____________

Employer____ Bus. Tel: (_____) ____________________

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above):

Name____ Relation__________________ S.S.#______________________ Birth Date___________

Street ____ City _____________________________ State ______ Zip __________

Tel: (_____) ____________________ Employer____ Bus. Tel: (_____) ____________________

INSURANCE INFORMATION:

Student: ☐ Full Time ☐ Part Time ☐ Not School Name and Address____

Marital Status: ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated____

Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Do you belong to a PPO or HMO? ☐ Yes ☐ No

PRIMARY INSURANCE COMPANY:

Insurance Type: ☐ Dental ☐ Medical

Employer____

Bus. Address____

Bus. Tel: (____) ____

Ins. Co. Name____

Address____

_______________________ Tel: (_____) ____________________

Group # ______________ Group Name ______________________

Insured Party ____

Sex: ☐ Male ☐ Female Birth Date ___________________

Street___________________________ City__________________

State & Zip_____________ Tel: (_____) ____________________

S.S.#_________________ I.D. #__________________________

SECONDARY INSURANCE COMPANY:

Insurance Type: ☐ Dental ☐ Medical

Employer____

Bus. Address____

Bus. Tel: (____) ____

Ins. Co. Name____

Address____

________________________________ Tel: (_____) ____________________

Group # ______________ Group Name _______________________________

Insured Party ____

Sex: ☐ Male ☐ Female Birth Date ___________________________

Street____ City__________________

State & Zip________________________ Tel: (_____) ____________________

S.S.#________________________ I.D. #______________________________

DENTAL INFORMATION:

Reason for today's visit:_______________________________________ Are you in pain? ☐ No ☐ Yes For how long?_______________________

Please indicate any of the following problems by checking off the corresponding box:

☐ Discomfort, clicking, or popping of jaw ☐ Lost / broken filling(s) ☐ Stained teeth ☐ Difficulty closing jaw

☐ Red, swollen, or bleeding gums ☐ Teeth grinding / clenching ☐ Locking jaw ☐ Difficulty opening jaw

☐ A removable dental appliance ☐ Ringing in ears ☐ Bad breath ☐ Loose / shifting teeth

☐ Blisters / sores in or around the mouth ☐ Broken / chipped tooth ☐ Burning tongue / lips ☐ Food caught between teeth

☐ Prolonged bleeding from an injury / extraction ☐ Gum disease ☐ Toothache ☐ Swelling / lumps in mouth

☐ Recent infections or sore throat ☐ Other____

☐ My teeth are sensitive to ☐ Cold ☐ Hot ☐ Sweets ☐ Biting

MEDICAL HISTORY:

Are you in good health? ☐ Yes ☐ No Height___________ Weight____________ Are you under the care of a physician? ☐ Yes ☐ No
Have you had any illness, operation, or been hospitalized in the past five years? ☐ No ☐ Yes ____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Rheumatic fever	☐	☐	Are you immunosuppressed? (possibly from transplant surg.)	☐	☐	Problems w/ immune system? (possibly from med. / surg.)	☐	☐	Low blood sugar
☐	☐	Mitral valve prolapse							☐	☐	Kidney trouble
☐	☐	Heart murmur	☐	☐	Asthma	☐	☐	Bleeding tendency	☐	☐	Are you on dialysis?
☐	☐	High blood pressure	☐	☐	Hay fever / Sinus problems	☐	☐	Jaundice / Liver disease	☐	☐	Arthritis / Joint disease
☐	☐	Low blood pressure	☐	☐	Snoring / Sleep apnea	☐	☐	Hepatitis	☐	☐	Osteoporosis / Osteopenia
☐	☐	Chest pain / Angina	☐	☐	Respiratory problems	☐	☐	Infectious mononucleosis	☐	☐	Osteonecrosis
☐	☐	Heart attack(s)	☐	☐	Tuberculosis	☐	☐	Gallbladder trouble	☐	☐	Stomach ulcers
☐	☐	Irregular heart beat	☐	☐	Emphysema	☐	☐	Fainting spells	☐	☐	Contagious diseases
☐	☐	Cardiac pacemaker	☐	☐	Do you smoke?	☐	☐	Convulsions / Epilepsy	☐	☐	Delay in healing
☐	☐	Heart surgery	☐	☐	Do you use chewing tobacco?	☐	☐	Stroke	☐	☐	Anemia
☐	☐	Bronchitis / Chronic cough	☐	☐	Blood transfusion	☐	☐	Thyroid trouble	☐	☐	Tumor or growth
☐	☐	Chronic fatigue / Night sweat	☐	☐	Blood disorder	☐	☐	Diabetes	☐	☐	Radiation / Chemotherapy
☐	☐	Mental health problems	☐	☐	Bruise easily	☐	☐	A history of alcohol abuse	☐	☐	Eating disorder
☐	☐	Damaged heart valves	☐	☐	A history of drug abuse	☐	☐	Sexually transmitted diseases	☐	☐	AIDS
☐	☐	HIV	☐	☐	Eye disease / Glaucoma	☐	☐	Abnormal bleeding	☐	☐	Malignant hyperthermia

MEDICATION & ALLERGIES:

Are you now taking or have taken:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Nerve pills	☐	☐	Pain killers (including aspirin)	☐	☐	Muscle relaxers	☐	☐	Stimulants
☐	☐	Have you ever taken diet pills	☐	☐	Tranquilizers	☐	☐	Insulin / Diabetic drugs	☐	☐	Antidepressants
☐	☐	Blood thinners (Coumadin, Plavix, Aspirin)	☐	☐	Ant-histamines	☐	☐	Blood pressure pills	☐	☐	Cortisone
			☐	☐	Nitroglycerine / Nitro patch	☐	☐	Oral contraceptives	☐	☐	Recreational drugs
☐	☐	Steroids	☐	☐	Any bone density medication or Bisphosphonates (Aredia, Fosamax, Actionel, Zometa)	☐	☐	Antibiotics	☐	☐	Heart drugs
☐	☐	Digitalis							☐	☐	Hormonal drugs

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):_____________________________________

Are you allergic to or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Penicillin	☐	☐	Sulfa drugs	☐	☐	Local anesthetic	☐	☐	Sodium pentothal
☐	☐	Valium or other tranquilizers	☐	☐	Aspirin	☐	☐	Codeine or other narcotics	☐	☐	Latex / rubber
☐	☐	Pain pills	☐	☐	Soy / Eggs/ Yolk	☐	☐	Antibiotics	☐	☐	Amoxicillin

Please list other medication or antibiotic you are allergic to:

Please list any allergies other than drugs allergies:

1-4 below for women only: (women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control)

1) Is there a possibility of pregnancy? ☐ Yes ☐ No **2)** Expected delivery date: _____________________________
3) Are you nursing? ☐ Yes ☐ No **4)** Are you taking birth control pills: ☐ Yes ☐ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

X____ X____ X__________________________

Signature of Patient (Parent or guardian if Minor) **Reviewed By** **Date**

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney fees, and court costs.

X____ X__________________________

Signature of Patient (Parent or Guardian if Minor) **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X____ X__________________________

Signature of Patient (Parent or Guardian if Minor) **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X____ X__________________________

Signature of Patient (Parent or Guardian if Minor) **Date**