Beach Endodontics

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Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Cell _____

Occupation _____ Employed by _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Occupation _____ Phone _____

Referred by _____ Dentist's Name _____

What is the name of your dental insurance company? _____

Person Financially Responsible _____

Financial Policy

The patient is responsible for any deductible and estimated co-payment at the time services are rendered. If you have dental insurance, the filing of your insurance claim is not a guarantee of payment. Your dental insurance is a contract between you and your insurance company. In the event a claim is not paid by the insurance company, you will be personally responsible for the remainder of the fees due. If the services of a collection agency are necessary to collect an unpaid balance, the undersigned agrees to pay all costs of collection including attorney's fees and court costs. We accept credit cards, checks, debit cards, cash, HSA/FSA cards, and Care Credit as forms of payment. If paying by credit card, 3% will be added to cover the credit card fees and expenses incurred by the office. Other forms of payment will not incur the 3% additional cost.

Patient's Signature _____ Date _____

Emergency Contact _____ **Phone #** _____

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

HEALTH HISTORY

1.	AIDS	☐ Yes	☐ No
2.	Alcohol/Drugs Addiction	☐ Yes	☐ No
3.	Anemia	☐ Yes	☐ No
4.	Arthritis, Rheumatism	☐ Yes	☐ No
5.	Artificial Heart Valves	☐ Yes	☐ No
6.	Artificial Joints	☐ Yes	☐ No
7.	Asthma	☐ Yes	☐ No
8.	Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
9.	Blood Disease	☐ Yes	☐ No
10.	Cancer	☐ Yes	☐ No
11.	Congenital Heart Lesions	☐ Yes	☐ No
12.	Diabetes	☐ Yes	☐ No
13.	Epilepsy	☐ Yes	☐ No
14.	Fainting or dizziness	☐ Yes	☐ No
15.	Headaches	☐ Yes	☐ No
16.	Heart Attack	☐ Yes	☐ No
17.	Heart Murmur	☐ Yes	☐ No
18.	Heart Problems	☐ Yes	☐ No
19.	Hepatitis Type_____	☐ Yes	☐ No
20.	Herpes	☐ Yes	☐ No
21.	High Blood Pressure	☐ Yes	☐ No
22.	HIV Positive	☐ Yes	☐ No
23.	Injury to head/neck	☐ Yes	☐ No
24.	Kidney Disease	☐ Yes	☐ No
25.	Liver Disease	☐ Yes	☐ No
26.	Low Blood Pressure	☐ Yes	☐ No
27.	Mitral Valve Prolapse	☐ Yes	☐ No
28.	Nervous Problems	☐ Yes	☐ No
29.	Pacemaker	☐ Yes	☐ No
30.	Psychiatric Care	☐ Yes	☐ No
31.	Radiation Treatment	☐ Yes	☐ No
32.	Respiratory Disease	☐ Yes	☐ No
33.	Rheumatic Fever	☐ Yes	☐ No
34.	Sinus Trouble	☐ Yes	☐ No
35.	Stroke	☐ Yes	☐ No
36.	Tuberculosis	☐ Yes	☐ No
37.	Tumor or growth on head or neck	☐ Yes	☐ No
38.	Women:		
	Are you pregnant?	☐ Yes	☐ No
	Due date_____	☐ Yes	☐ No
	Are you nursing?	☐ Yes	☐ No
39.	Other		

_____

_____

_____

_____

MEDICATIONS

Do you have a medical condition which requires you to pre-medicate prior to dental treatment ☐ Yes ☐ No

List medications you are currently taking:

ALLERGIES ☐ Yes ☐ No

☐ Latex ☐ Penicillin

☐ Aspirin ☐ Local Anesthetic

☐ Other _____

_____

_____

Pharmacy name _____ Phone_____

Note: A change in your health status should be reported to the office at the earliest possible time.

HIPPA Authorization

I authorize my doctor to retrieve and send all pertinent information to my general dentist.
I authorize the release of information to all my insurance companies as necessary.
I authorize the use of this form on all submissions.
I authorize my doctor to act as my agent in helping me obtain payment from any insurance company.
I authorize payment directly to my doctor.
I may receive a written copy of the Notice of Privacy Practices if desired.
I understand no information from my dental records will be released to anyone outside this office without my written permission.

Patient's Signature _____ Date _____

(If a minor, parent or guardian must sign)