Endodontic Health of Palo Alto

PATIENT INFORMATION AND FINANCIAL POLICY

Patient's Name _____Age_____ Date of Birth_____

Address _____City, State, Zip_____

Home Phone _____ Work _____Mobile _____

E-mail _____Best Contact: **EMAIL MOBILE TEXT HOME** Best Time to Reach You: _____

SS# _____Marital Status: **SINGLE MARRIED WIDOWED DIVORCED**

Employer _____ Employer Address _____

Spouse's Name _____Spouse's Phone: (Work) _____ (Mobile) _____

Emergency Contact _____Relation _____ Emergency Phone _____

Do you have dental insurance? **YES NO** If YES, Insurance Carrier's Name _____

Group # _____ Phone _____**Subscriber's Name** _____

Relation to Patient _____ Subscriber's SS# _____ Subscriber's Date of Birth _____

Insurance Carrier Address, City, State, Zip _____

Employer/Co. Name _____Phone _____

Employer/Co. Address, City, State, Zip _____

HOW DID YOU HEAR ABOUT US? _____

OFFICE FINANCIAL POLICY:

FOR THOSE PATIENTS WITHOUT DENTAL INSURANCE:

Payment is expected at the time services are rendered. We accept cash, check, Visa, MasterCard, and Discover cards. Please note, a fee will be charged for returned checks. Most cases referred to our specialty practice are complex and may require multi-appointments in order to complete the treatment.

FOR THOSE PATIENTS WITH DENTAL INSURANCE:

Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file your claim on your behalf. The collection of benefits from insurance companies is the patient's responsibility. Most dental insurance benefits are subject to limitations, exclusions, deductibles, co-payments and maximum benefit coverage. In order to obtain your dental benefits, your insurance carrier often requires us to provide information before initiating treatment (preauthorization) for more complicated dental procedures. If payment for treatment is approved, you will be required to pay the "Estimated Patient Portion" and any deductible at the time of service. If you elect not to have your treatment preauthorized (some treatment does not require preauthorization) you will be required to pay for your dental treatment on the date of service. If you have made an overpayment because of your insurance benefit payment, you will be reimbursed. If your insurance company denies payment for any procedure because of a change in your benefits or eligibility, you are responsible for the full cost of the treatment. We accept cash, check, Visa, MasterCard, and Discover cards. Please note, a fee will be charged for returned checks.

The undersigned certifies that he/she has read and understands the foregoing, and is the patient, the patient's legal representative (if patient is under 18 years old), or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____ _____

Signature of Patient/Parent/Guardian Date

Endodontic Health of Palo Alto

CONFIDENTIAL HEALTH HISTORY

Today's Date:_____

PATIENT'S FIRST NAME | **Middle Initial** | **LAST NAME** | **Date of Birth** (/ /)

I. Circle appropriate answer (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, please explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, please explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last 3 years?
   If YES, please explain: _____
4. Yes / No Are you being treated by a physician now?
   If YES, please explain: _____
   Date of last medical exam: _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, please explain: _____
   Date of last dental exam: _____ Name of dentist: _____
6. Yes / No Do you have reservations about particular dental treatments?
   If YES, please explain: _____

II. Have you experienced any of the following? (Please circle YES or NO for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. Have you had, or do you have, any of the following? (Please circle YES or NO for each)

Yes / No	Heart disease	Yes / No	Cosmetic surgery	Yes / No	Eating disorders
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancers	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
				Yes / No	Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to, or have you had a reaction to any of the following? (Please circle YES or NO for each)

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

OTHERS: _____

CONFIDENTIAL HEALTH HISTORY (CONTINUED)

V. Are you taking or have you taken any of the following in the last 3 months? (Please circle YES or NO for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Cortico-Steroids	Yes / No			

Please list the medications and herbal supplements that you are currently taking:

_____

_____

_____

VI. WOMEN ONLY (Please circle YES or NO for each)

Yes / No Are you, or could you be, pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle YES or NO for each)

Yes / No Do you have, or have you had, any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
Yes / No Have you ever been pre-medicated for dental treatment?
If YES, please explain: _____
Yes / No Have you ever taken Fen-Phen?
If YES, when: _____

Yes / No Is there any issue or condition you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize my dentist to contact my physician.

_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Physician's name Physician's phone number

_____
Physician's address

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have mad in the completion of this form.

_____ _____
Signature of Patient/Parent/Guardian Date