Patient Information

Patient Name: _____ Date: _____
Last, First MI

Address: _____
Street Apt. #

_____
City State Zip Code

Phone: _____
Home Work Ext Cell

Email Address: _____ _____/_____/_____ _____-_____-_____
Date of Birth (MM/DD/YEAR) Social Security Number

Emergency Contact: _____
Name Phone #

Health Information

Date of Last Dental Visit: _____ General Dentist: _____

Have you ever had any of the following? Please check those that apply.

- o Allergies: _____
  _____
- o Arthritis
- o Artificial Joints
- o Asthma
- o Blood Disease
- o Cancer
- o Diabetes
- o Dizziness
- o Epilepsy
- o Emphysema
- o Excessive Bleeding
- o Fainting
- o Glaucoma
- o Growths
- o Hay Fever
- o Head Injuries
- o Heart Disease
- o Heart Murmur
- o Hepatitis
- o HIV
- o High Blood Pressure
- o Jaundice
- o Kidney Disease
- o Liver Disease
- o Mental Disorders
- o Nervous Disorders
- o Pacemaker
- o **Pregnant**
  Due Date: _____
- o Radiation Treatment
- o Respiratory Problems
- o Rheumatic Fever
- o Rheumatism
- o Sinus Problems
- o Stomach Problems
- o Stroke
- o Tuberculosis
- o Tumors
- o Ulcers
- o Venereal Disease
- o Codeine Allergy
- o Penicillin Allergy

OTHER:
- o _____
- o _____

- Have you ever had any complications following dental treatment?
  If yes please explain: _____
- Have you ever been admitted to a hospital or needed emergency care during the past two years?
  If yes please explain: _____
  Name of Physician: _____ Phone #: _____
- Are you now being treated for any medical conditions?
  If yes please explain: _____
- Do you have any health problems that need further clarification?
  If yes please explain: _____

Please list all medications and over the counter prescriptions below.

Patients with In Network Dental Insurance

Our office is currently in network with two dental insurance companies, Northeast Delta Dental and Cigna. If subscriber information is received before your scheduled appointment we will contact your insurance company for a cost estimate of your copayment. If treatment is completed in one visit, your copayment must be received in full at that time. If more than one visit is required, payment may be split into two equal payments. **Please keep in mind; this is only an estimate and coverage verification does not guarantee payment. It also does not guarantee the estimated cost given to you is the total amount due.**

Patients with Out of Network Dental Insurance

We accept and submit to all out of network insurance companies with the exception of Medicare/Medicaid. If subscriber information is received before your scheduled appointment we will contact your insurance company for a cost estimate of your out of pocket expense. If treatment is completed in one visit, your out of pocket estimate must be received in full at that time. If more than one visit is required, payment may be split into two equal payments. **Please keep in mind; this is only an estimate and coverage verification does not guarantee payment. It also does not guarantee the estimated cost given to you is the total amount due.**

Patients without Dental Insurance

Patients who do not have any dental insurance are required to pay in full by the completion of treatment. If treatment is completed in a single visit, full payment is due at that time. If more than one visit is required, payment may be split into two equal payments. We do offer CARE CREDIT for those in need of financing.

Refunds/Remaining Balance

We will file your insurance claim electronically that same day to expedite payment. If the insurance payment is less than the estimated amount, you will be responsible for the balance. Failure to pay the remaining balance will result in our accounting office posting your debt to a collections agency**. If it becomes necessary to post your debt to a collections agency, the amount of the total remainder owed will be increased by 30 percent.** If the insurance payment is more than the estimated amount, you will be sent a refund check from our accounting office at the completion of your treatment.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I have any change in my health I will inform the doctors at my next appointment. I authorize the office of Smart Endodontics to release any and all information concerning the patient's treatment to all insurance companies for claims submitted and to verify insurance coverage for myself and/or spouse/dependents. I also authorize the payment of any insurance benefits from our in-network dental insurance plans directly to Smart Endodontics. I understand that any amount unpaid by insurance is my responsibility. If it becomes necessary for my account to be placed with a collection agency, I understand that I will be responsible for the collection fee of 30 percent that will be added on to the balance that is past due. I acknowledge that I have read and understand the financial policy for Smart Endodontics, PC. All insurance claims are sent upon the completion of any procedure and will take approximately 30 days to process. I understand that I am ultimately responsible for this account and should watch for the explanation of benefits for my insurance company to insure that the claim is processed expeditiously. Patients who have completed root canal therapy will be mailed a postcard informing them of the need to make a follow up appointment.

Signed: _____ **Date:** _____