Washington Square Endodontics

Dear Sir/Madam,

We are delighted to welcome you to our practice and are pleased that you chose us to serve your endodontic needs. We look forward to providing superior care to you.

To facilitate our first visit, please print out and fill in the patient information forms in this PDF file. Please remember to bring the information with you for your scheduled appointment.

The estimated portion of payment that you will owe is requested on the day of your treatment. We will estimate this on the phone and formalize that at the beginning of our appointment. Please inquire if you're interested in Care Credit, a 0% interest financing plan.

If for any reason you need to change this appointment, we ask that you give us 48 hours notice. We will gladly reschedule the appointment to a more convenient time. If you have any further questions, please let us know. We look forward to meeting you and serving your endodontic needs.

Sincerely,

The Washington Square Endodontics Team

Washington Square Endodontics

Patient Information

Name _____ _____ _____
Last First Middle Initial

Address _____ _____ _____ _____
Street City State Zip Code

_____ _____ _____ _____ _____ - _____ - _____
Home Phone Cell Phone Birth Date Marital Status Social Sec. No. (for insurance purposes)

_____ May we text you? Yes No
Email address

Whom may we thank for referring you to our office? _____

Primary Dental Insurance _____

Primary Insurance policy holder_____ Relationship _____ DOB_____

Secondary Dental Insurance _____

For Insurance information, we will scan both sides of your insurance card.

Responsible party and contact information. (If different than patient: list name, address, DOB, phone)

_____

_____

Emergency Contact_____ Relationship _____ Phone _____

Note on Insurance

To avoid misunderstanding regarding dental insurance, we wish to emphasize that as dental care providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. Dental insurance, by design, is usually meant to be an aid rather than pay-all. Unlike major medical insurance, the amount (co-payment) or remaining balance, less what the insurance company pays, is typically higher. We do not believe that it is in your best interest to base your treatment on the limitations of your particular insurance program.

Assignment of Benefits

The information provided is correct to the best of my knowledge. This includes any medical history and insurance information. I understand it is my responsibility to inform this office of any change in my medical and insurance status.

- In order to process your insurance claims, we will need your signature to release payment.
- I authorize release of any information relating to any claim for services rendered to me or my dependents.
- I assign and request your company to pay directly to the doctors of Washington Square Endodontics insurance benefits otherwise payable to me or my dependents.
- After 90 days, any unpaid balance will be subject to a $50 rebill fee.
- I understand I am financially responsible to Washington Square Endodontics for charges not covered by this assignment, and that a delinquent account may be referred to a collection agency.

_____ _____
Patient signature (If minor, parent's or guardian's signature) Date

Washington Square Endodontics

Patient Health History

These questions are confidential and help us provide better care

1. Are you in good health? YES NO
2. Have you seen a physician in the last 2 years? YES NO
3. Do you have any allergies? Penicillin? Latex? YES NO
   If yes, please list: _____
4. Are you sensitive to epinephrine? YES NO
5. Have you had an unfavorable reaction to dental treatment? YES NO
   If yes, please list: _____
6. Have you ever had excessive bleeding requiring special treatment? YES NO
7. Have you had any other serious illness? YES NO
   If yes, please list: _____
8. If female, are you or might you be pregnant? Which month? _____ YES NO
   Are you nursing? YES NO
9. Are you in a high risk group for infectious diseases? _____ YES NO
10. Please mark any of the following illnesses you have had:

o Anemia	o Depression/Anxiety	o Hepatitis (Type)	o Low Blood Pressure	o Sinus Problems
o Arthritis	o Diabetes	o Liver Disease	o Mental Disorders	o Stomach Problems
o Artificial Joints	o Dizziness	o Heart Condition/Disease	o Nervous Disorders	o Stroke
o Asthma	o Drug Abuse	o Heart Murmur	o Penicillin Allergy	o Tuberculosis
o Blood Disease	o Epilepsy	o High Blood Pressure	o Radiation Treatment	o Tumors
o Cancer (Type)_____	o Fainting	o HIV	o Respiratory Problems	o Ulcers or Colitis
o Codeine Allergy	o Growths	o Jaundice	o Rheumatic Fever	
o Cold Sores/Herpes	o Head Injuries	o Kidney Condition/Disease	o Other _____	

11. Major surgeries? _____

12. Are you taking any of the following (circle all that apply): antibiotics/sulfa drugs anticoagulants (blood thinners) medication for high blood pressure cortisone (steroids) tranquilizers insulin tolbutamide or similar drug aspirin digitalis or drugs for heart nitroglycerin bisphosphonates (like Fosamax)

    Please list all other medications that you take: _____

13. Name of your general physician: _____ Phone Number _____

The information provided is correct to the best of my knowledge. This includes any medical history and insurance information. I understand it is my responsibility to inform this office of any change in my medical and insurance status.

_____ _____

Patient signature (If minor, parent's or guardian's signature) Date

_____ _____ _____

Asst. Initial After Review Doctor's Signature Date

Washington Square Endodontics

Patient Symptoms

Date: _____

1. Are you experiencing any pain at this time? If not, please go to question 7. Yes No
2. If yes, can you locate the tooth that is causing the pain? Yes No
3. When did you first notice the symptoms? _____
4. Did your symptoms occur suddenly, or gradually? _____
5. Please indicate the level of intensity of the pain you are experiencing currently (on a scale of 1 to 10) where 1 = mild 10 = the most severe you could think of: _____
6. Please circle the words below that best describe the frequency and type of pain you are experiencing:

   Constant Sharp Intermittent Dull Momentary Throbbing Occasional

   Is there anything you can do to relieve the pain? Yes No

   If yes, what? _____

   Is there anything you can do to cause the pain to increase? Yes No

   If yes, what? _____

   When eating or drinking, is your tooth sensitive to: Heat Cold Sweets

   Does your tooth hurt when you bite down, or chew? Yes No

   Does it hurt if you press the gum tissue around the tooth? Yes No

   Does a change in posture (lying down or bending over) cause your tooth to hurt? Yes No
7. Do you grind or clench your teeth? Yes No
8. If yes, do you wear a night guard? Yes No
9. Has a restoration (filling or crown) been placed on this tooth recently? Yes No
10. Prior to today, has root canal therapy been started on this tooth? Yes No
11. Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis?

    Please explain: _____

    _____

Assistant Notes:

Washington Square Endodontics

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I understand that Washington Square Endodontics (referred to below as "the office") will use and disclose health information about me in the course of providing dental care to me.

I understand that my health information may include information both created and received by the office, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the office is permitted to use and disclose my health information in order to:

1) make decisions about and plan for my care and treatment;

2) refer to or consult and coordinate with other dental/healthcare providers in the course of my treatment;

3) determine my eligibility for dental plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my dental care; and perform various office, administrative and business functions that support the office's ability to provide me with the appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the office's Notice of Privacy Practices in effect will be posted in the office.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the office is not required by law to agree to such requests.

By signing below, I agree that I have received or been offered a copy of this office's Notice of Privacy Practices.

_____ _____

Patient Date

OR

_____ _____ _____

Patient's Representative Date Description of Representative's Authority