Patient Information

Date _____/_____/_____

PATIENT General Dentist's Name: ______________________Referring Dentist's Name: ______________________________

Name_______________________________________ Date of Birth _____/_____/_____ Social Security # ______-____-_______

Address ____ City ________________________ State _________ Zip ____________

Phone: Home (_____)_________________ Cell (_____)__________________ Work (_____)__________________________

Email Address ____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer ____ Address ____

RESPONSIBLE PARTY *(The person to whom bills will be sent)* ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other ______________

Name________________________________ Date of Birth _____/_____/_____ Social Security # _________-______-_________

Address ____ City ______________________ State ___________ Zip _________

Phone: Home (_____)_______________________ Cell (_____)_____________________ Work (_____)____________________

Email Address ____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer ____________________________________ Address ____

IF YOU WISH FOR OUR OFFICE TO SUBMIT YOUR INSURANCE CLAIM FOR YOU, PLEASE COMPLETE INFORMATION BELOW.
Please present a copy of your dental insurance card to the Patient Services Specialist.

DENTAL INSURANCE Insured's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian

Name of Insured __________________________ Date of Birth _______/_______/_______ Social Security # _____-____-______

Dental Insurance Company ______________________________ Group # _________________ Plan ID ____________________

Employer _______________________ Address ________________________ City ________________ State ____ Zip _________

SECONDARY DENTAL INSURANCE Insured's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian

Name of Insured ________________________ Date of Birth _______/_______/_______ Social Security # ______-_____-______

Dental Insurance Company ___________________________ Group # _____________________ Plan ID ___________________

Employer _______________________ Address ________________________ City _________________ State _____ Zip _______

Authorization to Release Information: Advanced EndoCare is authorized to provide any insurance carrier(s), claims administrator(s), and consulting healthcare professionals, information concerning health care, advice, treatment, or supplies provided. In consideration of treatment rendered to the above named patient, I accept full financial responsibility. An insurance claim will be submitted electronically as a convenience to the patient. Payment is expected at the time services are rendered. I further agree that if this account is turned over to an attorney or collections agency, I will be responsible for all collection costs, court costs, interest of 21%, and reasonable attorney fees.

____

SIGNATURE OF RESPONSIBLE PARTY DATE

Health History

Please indicate whether you have had or currently have each of the following by circling "Yes" or "No" to each item

Patient Name:______________________________
Date:

Heart (surgery, disease, or attack)	Yes	No
Chest Pain / Angina	Yes	No
Congenital Heart Disease	Yes	No
Heart Murmur	Yes	No
High Blood Pressure	Yes	No
Mitral Valve Prolapse	Yes	No
Artificial Heart Valve	Yes	No
Heart Pace Maker	Yes	No
Rheumatic Fever	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No
Arthritis / Rheumatism	Yes	No
Cortisone Medication	Yes	No
Swollen Ankles	Yes	No
Stroke	Yes	No
Diet (special or restricted)	Yes	No
Ulcerative Colitis	Yes	No
Kidney Trouble	Yes	No
Ulcers	Yes	No
Diabetes	Yes	No
Thyroid Problems	Yes	No
Emphysema / Lung Disease	Yes	No
Chronic Cough	Yes	No
Tuberculosis	Yes	No
Asthma	Yes	No
Allergies or Hives	Yes	No
Latex Sensitivity	Yes	No
Fainting / Dizzy Spells	Yes	No
Sinus Trouble	Yes	No
TMJ / Pain in Jaw Joint	Yes	No
Glaucoma	Yes	No
Radiation Therapy	Yes	No
Chemotherapy	Yes	No
Tumors	Yes	No
Cancer	Yes	No
Hepatitis (A,B, or C)	Yes	No
Venereal Disease	Yes	No
Herpes	Yes	No
HIV Positive	Yes	No
AIDS	Yes	No
Blood Transfusion	Yes	No
Anemia	Yes	No
Hemophilia	Yes	No
Sickle Cell / Bleeding Disorder	Yes	No
Bruise Easily	Yes	No
Liver Disease	Yes	No
Yellow Jaundice	Yes	No
Neurological Disorders	Yes	No
Epilepsy or Seizures	Yes	No
Psychiatric Psychological Care	Yes	No
Nervous / Anxiety	Yes	No
Herbs / Supplements	Yes	No
Smoke	Yes	No
Alcoholism	Yes	No
Drug Addiction	Yes	No

Any other disease or condition?__________________

Are you taking any medication? Yes No
If so, please list:______________________________

Are you allergic to any medications? Yes No
If so, please list:____

When did you last see your medical doctor?
Date:____
Physician's Name:______________________________
Physician's Phone:_____________________________

Women:

Currently Pregnant	Yes	No
Currently Nursing	Yes	No
Birth Control Pills	Yes	No

Do you take any of the following:

Fosamax	Yes	No
Aredia	Yes	No
Zometa	Yes	No
Bonefos	Yes	No

General Dentists Name:________________________
Patient's Signature:___________________________
Date:

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Medical Information Release Form
HIPAA Release Form

Name: ____ Date of Birth:______/______/______

We are unable to discuss your treatment with anyone unless you give us written permission.

[ ] I authorize the release of information including the diagnosis, records, images, examination rendered to me, and claims information. This information may be released to:

> Please note: Certain treatments may require the patient be sedated. You will need to have a driver for such treatment. Your driver must be listed on this medical information release form prior to treatment.

[ ] My general and/or referring dentist
Names:____
[ ] Spouse Name: _______________________________________
[ ] Child(ren) Name(s): ___________________________________
[ ] Parent Name: _______________________________________
[ ] Other Name: ____

[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages

Please call my [ ] home [ ] work [ ] cell Number ____________________________

If unable to reach me:
[ ] You may leave a detailed message
[ ] Please leave a message asking me to return your call
[ ] Other ____

The best time to reach me is (day) ____________________________ between (time) ________________________

I have received a copy of this office's Notice of Privacy Practices.

Signed: ____ Date: _______/_______/______