## *Peninsula Endodontics*

**302 Bulifants Blvd., Suite 102**
**Williamsburg, VA 23188**
**757-903-2577(P) 757-903-2286 (F)**


## PATIENT INFORMATION

Name _____ Date of Birth _____

**Last name** **First Name** **Middle Initial**

Address _____ City _____ State _____ Zip _____

Male ____ Female ____ Soc.Sec.# _____ Home # _____ Cell # _____

Employer _____ Business Phone _____ E-mail _____

Business Address _____ City _____ State _____ Zip _____

Spouse/Parent Name _____ Address _____

Spouse/Parent Employer _____

Whom may we thank for referring you? _____

## PRIMARY DENTAL INSURANCE

Person Responsible for Account _____

**Last Name** **First Name**

Relationship to Patient _____ Date of Birth _____ Soc.Sec. # _____

Address _____ City _____ State ____ Zip _____

Person Responsible Employed By _____ Bus. Phone _____

Insurance Company _____

Phone # _____ Group # _____ Subscriber # _____

## DENTAL HISTORY

General Dentist _____ Phone # _____

Date of last dental care _____ Date of last x-ray _____

Are you having any dental problems at this time? _____ If so, what? _____

_____

Do you feel pain or popping of joints when opening or closing your mouth? _____ If so, when did you first notice this? _____

Has anyone in your family had oral cancer? _____ If so, who and when _____

Are you bothered by recurring or persistent canker sores, or other body sores? _____ If so, describe

_____

Have you had excessive bleeding requiring dental treatment? _____ If so, describe _____

**I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I authorize the insurance company to issue payment directly to the dentist. I authorize the use of this signature for all Insurance claims. I understand that I am responsible for all fees.**

SIGNATURE _____ DATE _____

**Welcome to Peninsula Endodontics**

# Health History

Date_____

Patient's name _____ Date of Birth _____

Please circle YES or NO, whichever applies

Your answers are for our records only and are considered confidential.

YES NO Do you consider yourself in good health at this time?
YES NO Have there been any changes in your general health in the last year?
YES NO Have you ever been instructed to take pre-medication before dental treatment?
YES NO Have you ever taken Phen-Fen or any other diet pills?

**Do you have any of the following conditions?**

YES NO Damaged heart valves, pacemaker, artificial arteries or grafts
YES NO History of Rheumatic Fever or Scarlet Fever
YES NO Congenital heart defect or heart murmur
YES NO Cardiovascular disease, heart attack, hypertension, stroke or cardiac insufficiency
YES NO Artificial joints or surgically placed prosthesis, including hip or knee joints
YES NO Low blood pressure or fainting
YES NO Seizures or epilepsy
YES NO Diabetes or blood sugar problems
YES NO Liver disease, history of jaundice or hepatitis
YES NO Kidney disease or stomach ulcers
YES NO Tuberculosis or Asthma
YES NO History of smoking: Amount per day Number of years
YES NO Alcoholism, drug use or dependence
YES NO Psychotherapy or nervous conditions
YES NO History of bleeding problems, blood disorders or Anemia
YES NO Immune compromises, including HIV,ARC OR AIDS
YES NO Have you ever had treatment of cancer including x-rays treatment or chemotherapy
YES NO Do you have any diseases, conditions or problems other than those listed above?

If yes, please provide more detail.

_____

_____

**Do you have any allergies or adverse reaction to any of the following medications?**

YES NO Penicillin or other antibiotics
YES NO Aspirin or Ibuprofen
YES NO Sulfa drugs or Iodine
YES NO Codeine or other narcotic medications
YES NO Valium, Sedatives or sleeping pills
YES NO Have you or any blood relative had any adverse reaction to local or general anesthetic?
YES NO Other

If yes, please provide more detail.

_____

_____

## Welcome to Peninsula Endodontics

**Women:**

YES NO Are you pregnant or possibly pregnant at this time?
YES NO Are you currently a nursing mother?

**All Patients:**

YES NO Have you traveled to a foreign country within the last 30 days? If Yes, Do you have flu-like symptoms and/or fever?_____

Are you currently taking any of the following medication?

YES NO Antibiotics
YES NO Anticoagulants (blood thinners)
YES NO Blood Pressure medications.
YES NO Steroids
YES NO Tranquilizers or Antihistamines
YES NO Aspirin, Ibuprofen or Naproxen (Aleve)
YES NO Insulin, Tolbutamide (Orinase) or other blood sugar altering medications
YES NO Digitalis, Nitroglycerine or other heart medication
YES NO Oral contraceptives
YES NO Any other prescription medications. Please list the medication and dosage:

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore, I have reviewed this health history carefully and have answered all questions to the best of my knowledge.

_____ _____

Signature of patient (or legal guardian) Date

## Peninsula Endodontics

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: PATIENT GIVING CONSENT**

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Number: _____ SSN: _____

**SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent**: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Kalisha Jordan, D.D.S., M.S.D._____

Telephone: (757)903-2577____ Fax: (757)903-2286_____

Email: info@peninsulaendo.net_____

Address: 302 Bulifants Blvd., Ste. 102, Williamsburg, VA 23188_____

**Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**Signature**

**I, _____,** have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**Signature: _____ Date: _____**

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name_____

Relationship to Patient: _____

*Peninsula Endodontics*
**302 Bulifants Blvd., Suite 102**
**Williamsburg, VA 23188**

# Financial Policy

The fee for Endodontic therapy is determined by the complexity of the tooth being treated. **Therefore, we can only give an estimate of the charges in advance of treatment.** All payments are due at the time services are rendered. You must provide valid evidence insurance of coverage.

Peninsula Endodontics participates with the following dental benefit plans:

- Delta Dental (all plans)
- Connection Dental
- DenteMax
- Aetna
- GEHA
- Cigna
- Anthem BCBS

If you are a member of one of these plans, please note the following:

- You are responsible for any co-payments/deductible not met at time of service.
- You are responsible for any amounts over your contracted benefit amount. For example: In network patients are responsible for the contracted fee amount, if your yearly benefit amount is $900.00 and you have used $900.00, in network patients will be responsible for 100% of the contracted amount, out of network patients would be responsible for 100% of our standard fees.
- You are responsible for knowing your insurance policy and what endodontic procedures are covered.
- **When a service is not covered and the member is put on notice that the service may not be covered, the member will be financially responsible for the full cost of the service**.

If Peninsula Endodontics does not receive payment from your insurance company within 30 days from the date of service, you will be expected to pay the balance in full. Any unpaid balances due after 30 days of mailed statements will be sent to collections. I understand that I am responsible for payment and agree to pay any and all court costs, interest, legal fees and collection agency fees in the amount of 33.3% of the total amount due, in the event my account is placed for collections. We apologize but we do not file secondary insurance for out of network policies.

I have read and understand the Peninsula Endodontics financial policy, and I consent to the policy.

Print name_____ Date_____

Signature_____

*Peninsula Endodontics*

**302 Bulifants Blvd., Suite 102**

**Williamsburg, VA 23188**

**757-903-2577(P) 757-903-2286(F)**

# Cancellation/No Show Policy

Our goal here at Peninsula Endodontics is to provide quality Endodontic care in a timely manner. We have implemented an appointment cancellation policy which enables us to better utilize available appointments for our patients in need.

## Cancellation of Appointments

Please be courteous and call Peninsula Endodontics promptly if you are unable to attend an appointment. This time can be reallocated to someone in urgent need of treatment.

If it is necessary to cancel your appointment we require that you give at least 24 hours' notice. There will be a $25.00 cancellation fee for any appointments cancelled after that time. Available appointments are in high demand and your early cancellation will help another patient in need.

A failure to present at time of a scheduled appointment will be recorded in the patients chart. After three no shows a patient can be dismissed from service.

Signature _____Date_____