ARCS Advanced Root Canal Specialists of MA, P.C.

Laser microsurgery - a gentle approach.

ROBERT W. PASSLOFF, D.M.D. • KEVIN A. RUBIN, D.M.D. • DEVIKA KAPOOR, D.M.D.
Practice limited to endodontics.

PATIENT REGISTRATION AND MEDICAL HISTORY (*PLEASE PRINT*) DATE _____

Patient _____
Last Name *First Name* *Initial* *Preferred Name*

Street Address _____ City_____ State _____ Zip_____

Home Phone _____ Cell_____ Work_____

E-Mail Address _____

Sex: ☐ M ☐ F Birthdate _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by_____ Occupation _____

Business Address _____ Business Phone _____

Spouse/Parent Name_____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by_____ Occupation_____

Business Address _____ Business Phone_____

Who is responsible for this account? _____ Relationship to Patient_____

Patient's Social Security #_____ Spouse/Parent SS #_____

Dental Insurance Co._____ Group Number _____

In Case of Emergency Notify _____ Phone_____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical_____

Have you ever had any of the following? (Check those that apply):

☐ Heart Problems	☐ Epilepsy	☐ Special Diet
☐ High Blood Pressure	☐ Headaches	☐ Swollen Neck Glands
☐ Low Blood Pressure	☐ Hepatitis, Jaundice or Liver Disease	☐ Rheumatic Fever
☐ Circulatory Problems	☐ Cancer	☐ Sinus Problems
☐ Nervous Problems	☐ Psychiatric Care	☐ HIV/AIDS
☐ Radiation Treatment	☐ Chronic Diarrhea	☐ Other Immunosuppressive Disorders
☐ Artificial Heart Valves or Joints	☐ Allergies to Anesthetics	☐ Stroke
☐ Recent Weight Loss	☐ Allergies to Medicine or Drugs	☐ Ulcer
☐ Back Problems	☐ General Allergies	☐ Venereal Disease
☐ Diabetes	☐ Blood Disease	☐ Chemical Dependency
☐ Respiratory Disease	☐ Arthritis	☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, what_____

Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication at this time?_____ If so, what_____

Have you ever taken any of the group of drugs collectively referred to as “fen-phen”? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)._____

Are you under the care of a physician?_____ For what conditions?_____

If patient is a child what is his/her weight?_____

(Woman) Do you suspect that you are pregnant?_____ Are you nursing?_____

Is there anything else we should know about your medical history?_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment , billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____ (*Please turn page*)

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____

Name of Insurance Company (ies)

And assign directly to Dr._____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date_____ Signature_____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and

Name of minor/child

authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date _____ _____

Signature of Insured/Guardian

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date_____ _____

Signature of Insured/Guardian

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last appointment at this office? Yes_____ No_____

For what conditions? _____

Are you taking any new medications?_____ If so, what _____

Date_____ Patient Signature _____

Date_____ Dentist Signature _____

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Has there been any change in your health since your last appointment at this office? Yes_____ No_____

For what conditions? _____

Are you taking any new medications?_____ If so, what _____

Date_____ Patient Signature _____

Date_____ Dentist Signature _____

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