NORTH SUBURBAN ENDODONTICS

WELCOME TO OUR OFFICE!

In order to serve you properly we will need the following information. (Please print.) All information will be strictly confidential.

DATE ______________________

PATIENT (Ms.) (Mr.) (Mrs.) (Dr.) ______________________
Last First M.I. Nickname

ADDRESS ______________________
(IF P.O. BOX GIVE STREET ADDRESS ALSO)

CITY ______________ STATE ______________ ZIP ______________

HOME/CELL ______________ WORK ______________ EXT ______ Email ______________

DATE OF BIRTH ______________ SEX M ☐ F ☐ SOCIAL SECURITY NUMBER ______________

EMPLOYER'S NAME ______________ NAME OF SPOUSE ______________

EMPLOYER'S ADDRESS ______________ PHYSICIAN ______________

WHO MAY WE THANK FOR REFERRING YOU? ______________ GENERAL DENTIST ______________

BILLING INFORMATION (IF DIFFERENT FROM ABOVE)

NAME OF RESPONSIBLE PARTY ______________ DATE OF BIRTH ______________

ADDRESS ______________ RELATIONSHIP TO PATIENT ______________

HOME PHONE ______________ WORK PHONE ______________ EXT ______________ SEX M ☐ F ☐

EMPLOYER'S NAME ______________ SOCIAL SECURITY NUMBER ______________

PAYMENT FOR OFFICE VISITS ARE DUE AT THE TIME OF TREATMENT. PLEASE INDICATE YOUR CHOICE OF PAYMENT. WE ACCEPT THE FOLLOWING. WE WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU HAVE.

CASH ☐ CHECK ☐ MASTER CARD ☐ VISA ☐ DISCOVER ☐

DO YOU HAVE DENTAL INSURANCE: YES ______________ NO ______________

PLEASE FURNISH INSURANCE INFORMATION OR COMPLETED FORM ON FIRST VISIT.

NAME OF INSURANCE COMPANY ______________

ADDRESS OF INSURANCE COMPANY ______________

NAME OF INSURED PERSON ______________ ID# ______________ DOB: ______________

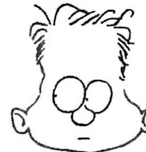
EMPLOYER OF INSURED ______________ GROUP# ______________

PLEASE, let us know how you're feeling today!

CONFIDENT

OPTIMISTIC

HAPPY


CURIOUS

UNDECIDED

CAUTIOUS

FRIGHTENED

ANXIOUS

PAINED

MISERABLE

PLEASE FILL OUT REVERSE SIDE ALSO

MEDICAL HISTORY

Please circle any of the following which may apply to you now or in the past:

Tuberculosis	Heart Failure	Angina Pectoria	Sinus Trouble	Liver Disease
High Blood Pressure	Heart Disease or Attack	Allergies or Hives	Yellow Jaundice	Bleeding Problems
Diabetes	Artificial Heart Valve	Heart Pacemaker	Drug Addicition	Anemia
Ulcers	Rheumatic Fever	Congenital Heart Lesions	Thyroid Disease	Artificial Joint
Systemic Bacteremia	Mitral Valve Prolapse	Hepatitis A (infectious)	Pain in Jaw Joints	Fainting or Dizzy Spells
Fungal Infection	Heart Murmur	Hepatitis B (serum)	AIDS	Bruise Easily
Glaucoma	Heart Surgery	Hepatitis C	HIV Positive	Epilepsy or Seizures

Latex Allergy YES ☐ NO ☐

Do you need to pre medicate with antibiotics prior to any dental treatment? YES ☐ NO ☐

Any other diseases or problems? ____________________

WOMEN: Are you pregnant? ____________________ If so, what month? __________

Have you ever had an unusual reaction to an anesthetic or drugs? (Penicillin, Erythromycin, Novacaine, Codeine, Aspirin, other) YES ☐ NO ☐ If yes, please explain ; ____________________

____

____

Medications taking at present ; ____________________

____

Have you taken Aspirin or Ibuprofen in the last 72 hours? YES ☐ NO ☐ Aspirin ☐ Ibuprofen ☐

Approximately how many? ____________________

The purpose of endodontic treatment or root canal treatment is an attempt to save a tooth rather than removing it. Although treatment has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal treatment may require retreatment, surgery or even extraction.

Treatment is usually a non-surgical procedure, but in some cases, a surgical approach is necessary. Before any treatment has begun the reason(s) will be fully explained, including alternative modes of therapy, and any possible complications involved. Occasionally, premedication may be indicated. This will be discussed in advance.

THE FEE WILL NOT INCLUDE A PERMANENT FILLING OR CROWN ON THE TOOTH. YOU MUST RETURN TO YOUR GENERAL DENTIST TO HAVE THAT TREATMENT COMPLETED.

I understand I am financially responsible for all services and fees incurred.
An interest rate of 1.5% will be added to all balances over 60 days.

DATE __________ SIGNATURE ____________________
(patient, or parent/guardian of minor patient)

I hereby authorize my insurance benefits to be paid directly to North Suburban Endodontics and I also authorize the Doctor to release any information required to process insurance claims.

DATE __________ SIGNATURE ____________________
(patient, or parent/guardian of minor patient)