**MedArt Endodontics, LLC**

# Patient Registration

(Please Print)

○ Mr.
○ Miss.
○ Mrs.
○ Ms.
○ Dr.
○

Date:_____

_____

Prefix | Last Name | First Name | Middle Initial

Address_____ Date of Birth _____

Street | City | State | Zip

Social Security # _____ If patient is a minor, responsible parent _____ Home Phone _____
Business Phone _____ Employed by _____ Occupation _____
General Dentist _____ Referred by _____
Physician _____ Phone _____ Date of Last Physical _____
In case of emergency contact _____ Relationship _____ Phone _____

## Health History

Are you under the care of a physician? Yes ☐ No ☐ For what condition? _____
In the last five years, have you ever been: (If yes, please circle and explain)
Hospitalized: Yes ○ No ○ _____
Had a serious illness? Yes ○ No ○ _____
Do you have a prosthetic joint? Yes ○ No ○ If so, describe where: _____
Do you have a heart valve replacement of vascular graft? Yes ○ No ○ Where? _____
Must you take an antibiotic before dental treatment? Yes ○ No ○ If so, what and how many? _____

| Have you had or do you currently have… | Yes | No | Notes | Have you had or do you currently have… | Yes | No | Notes |
|---|---|---|---|---|---|---|---|
| Heart murmur | ☐ | ☐ | | Kidney disease | ☐ | ☐ | |
| Mitral valve prolapse | ☐ | ☐ | | Tuberculosis | ☐ | ☐ | |
| Rheumatic fever | ☐ | ☐ | | Asthma | ☐ | ☐ | |
| High blood pressure | ☐ | ☐ | | Anemia | ☐ | ☐ | |
| Chest pain, angina | ☐ | ☐ | | Hepatitis/liver disease | ☐ | ☐ | |
| Heart attack | ☐ | ☐ | | Arthritis | ☐ | ☐ | |
| Stroke | ☐ | ☐ | | Ulcers | ☐ | ☐ | |
| Cardiac pacemaker | ☐ | ☐ | | HIV/AIDS | ☐ | ☐ | |
| Heart surgery | ☐ | ☐ | | Seizures | ☐ | ☐ | |
| Thyroid trouble | ☐ | ☐ | | Glaucoma | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | | Sinusitis | ☐ | ☐ | |
| Cancer | ☐ | ☐ | | TMJ pain or "clicking" | ☐ | ☐ | |

**Medications:**_____

_____

_____

## Allergies

| Are you allergic to or have you had a reaction to: | Yes | No | Notes | Are you allergic to or have you had a reaction to: | Yes | No | Notes |
|---|---|---|---|---|---|---|---|
| Local anesthetics (Adrenalin) | ☐ | ☐ | | Codeine or other narcotics | ☐ | ☐ | |
| Penicillin | ☐ | ☐ | | Other medications | ☐ | ☐ | |
| Other antibiotics | ☐ | ☐ | | Other non-drug allergies | ☐ | ☐ | |
| Aspirin or Ibuprofen | ☐ | ☐ | | Latex | ☐ | ☐ | |

**Women:** Are you pregnant? Yes ☐ No ☐ If so, estimated delivery date: _____ Are you nursing? _____

Chief Dental Complaint_____

_____

Have you ever had a root canal before? Yes ☐ No ☐

Patient / (or Guardian) Signature _____ Date _____

## Insurance Information

Is treatment covered by insurance? Yes ☐ No ☐

Name of Insurance Company _____ Phone _____

Insurance address _____ City _____ State _____ Zip _____

Subscriber's Name _____ SS# _____

Birth Date _____ Patients Relationship to Subscriber _____

Subscriber's Address _____

Subscriber's Employer _____ Group or Policy # _____

Is patient covered by additional insurance? Yes ☐ No ☐ If "Yes" please complete information

Name of secondary insurance company _____ Phone _____

Insurance address _____

Subscriber's Name _____ SS# _____

Birth Date _____ Patient's relationship to Subscriber _____

Subscriber's Employer _____ Group or Policy # _____

** I understand that my dental insurance is a contract between the insurance carrier and myself, and not a contract between my insurance carrier and the Doctor. I understand that I am still FULLY responsible for all dental fees. I understand these fees are due and payable at the time services are rendered unless a prior financial arrangement has been made. I assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account or refunded to me in excess of the amount due.

_____

Patient / (or Guardian) Signature Date

## All Patients

I, the undersigned, certify that the information on these pages is correct and accurate. I also certify that I am the patient (or authorized agent of the patient) authorized to furnish all information requested.

I understand that all requested dental fees are due and payable at the time of service and I am fully responsible for these fees.

I agree that if my account is referred to an outside agency or attorney for collection, I will be responsible for an additional Collection Fee of fifty dollars ($50.00). Also, if there are repeated rescheduling requests on my part, I will be responsible for a Cancellation Fee of fifty dollars ($50.00) billable to the patient.

I/We have read this disclosure and agree.

Patient / (or Guardian) Signature _____ Date _____

To all **United Concordia** and **Delta Dental** patients:

There are certain conditions where a tooth cannot be saved. Sometimes it can be diagnosed during the consultation and then recommended not to proceed. Sometimes these conditions are not visible during the examination or visible by x-rays, or discovered when the tooth is treated. Some examples include microfractures, perforations, resorption, iatrogenic difficulties (previous treatment by another dentist that did not turn out favorably) and unusual anatomical configurations of the tooth. In today's modern endodontics, we now have surgical operating microscopes to detect certain unfavorable dental conditions during the procedure and thus stop treatment at that time.

In the event that your tooth is found to be unsalvageable during the course of root canal treatment or retreatment, and it ultimately needs to be extracted, we will not use the code for root canal treatment or retreatment. Instead, we will use the code for incomplete endodontic treatment. **United Concordia** insurance plans do not cover this fee, therefore, you will be responsible for the payment at the time of your visit. Some **Delta Dental** insurance plans will cover this fee, however, you are responsible for this fee at the time of your visit. We will submit this code on your behalf**.** In the event that Delta Dental does cover this code, we will refund your payment.

I understand that if this tooth is deemed unsalvageable during the treatment, and I have either **United Concordia** or **Delta Dental** insurance, I will be responsible for payment for Incomplete Endodontic Treatment at the time of service.

Patient / (or Guardian) Signature _____ Date _____