Piedmont Endodontics, LLC

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date_____ Patient's Name_____
Last First Middle

Responsible Person (if patient is a minor)_____
Last First Middle

Address_____ City_____ State_____ Zip_____

Home Ph# (___)_____ Work Ph# (___)_____ Cell Ph# (___)_____

Soc. Sec. #_____ Email_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐Single ☐Married ☐ Widowed ☐ Divorced

Patient Employed by_____ Occupation _____

Business Address_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone(___)_____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Middle

Relation to Patient _____ Birthdate _____ Soc. Sec. #_____

Address (If different from patient's)_____ Phone (___)_____

City_____ State_____ Zip_____

Person Responsible Employed By_____ Occupation _____

Business Address _____Business Phone (___)_____

Insurance Company_____Group#_____Phone (___)_____

Is patient covered by additional dental insurance? ☐ Yes ☐ No

If yes, please complete the following secondary insurance information.

Insured's Name _____ Relation to Patient _____

Insured's Soc. Sec. # _____ Insured's Birthdate _____

Insurance Company_____ Group #_____

Insurance Co. Address _____ Phone (___)_____

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

Print name:_____**Signature:**_____**Date:**_____

Patient refuses to sign HIPAA: Staff initial_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Are you currently under physicians care? ☐ Yes ☐ No If yes, why _____

Serious illnesses or operations in the last 5 years? ☐ Yes ☐ No If yes, describe _____

Do you need to pre-medicate with antibiotics for dental treatment? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Taking birth control pills/Hormone Therapy? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Emphysema
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ HIV/AIDS/ARC
- ☐ Jaw Pain TMJ/TMD
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

Patient Consent

I, the undersigned, consent to the performing of an endodontic exam and endodontic procedures that may be desired, necessary, or advisable after reviewing treatment options with the doctor. I have provided an accurate and complete medical and personal history including all current medications and allergies. I also understand that I am to promptly return to my dentist for a permanent restoration of the treated teeth.

Patient (Guardian) Signature_____ **Date:**_____

AUTHORIZATION AND FINANCIAL POLICY

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. If there is any change in my medical status, I will inform the dentist.

I authorize the dentist to release all information necessary to secure the payment of benefits.

It is your responsibility to understand how your insurance policy pays for services rendered. Our office participates with DELTA DENTAL and UNITED CONCORDIA.

IF YOU DO NOT HAVE INSURANCE ... Full payment is due at check-in prior to being seen by Dr. Vagnetti.

IF YOU HAVE INSURANCE...and we are preferred providers with the insurance carrier, then you are expected to pay your **percentage** at check-in prior to being seen by Dr. Vagnetti. Your percentage is due regardless of whether you have both a primary and secondary insurance carrier. However, if your maximum benefits have been met for the year, you will be required to pay in full. **INSURANCES WITH HMO, DHMO, OR MEDICAID ARE NOT ACCEPTED.**

IF YOU HAVE INSURANCE WITH ANOTHER CARRIER ... You will be expected to pay **100%** of our procedure fee at time service is rendered. As a courtesy, we will submit your insurance claim (primary only) so you will be reimbursed directly from the insurance company.

Signature_____ **Date** _____