Curt A. Warren, D.D.S. – Endodontics, P.C.

CONFIDENTIAL HEALTH HISTORY – PATIENT INFORMATION FORM

Patient Name: _____ Home Phone: _____
Address: _____ Work Phone: _____ Ext: _____
City/State/Zip: _____ Cell Phone: _____

Sex: M F Date of Birth: _____ Patient Social Security #: _____

How did you hear about our office? _____
Who is your dentist? _____
Have you had previous endodontic treatment? (Root Canal Therapy) _____

Rate your overall health: Good _____ Fair _____ Poor _____
Are you currently under the care of a physician? Yes_____ No _____
If yes, please explain: _____
Who is your medical doctor: _____
If female, are you pregnant? Yes _____ No _____ What month? _____
Have you ever had trouble with prolonged bleeding? _____
Have you ever had an allergic reaction to a drug, medicine or latex? _____
Is there any other information that we should know about your health? _____
_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

High Blood Pressure	Smoke	Epilepsy / Fainting	Heart Disease
Respiratory / Asthma	Cancer	Glaucoma / Visual	Heart Murmur / Defect
Rheumatic Fever	Radiation / Chemotherapy	Mental / Neural	Pacemaker
Hypertension / Circulatory	Tuberculosis	Tumor / Neoplasms	Heart Attack / Stroke
Immunocompromised	Fatigue	Alcoholism / Addiction	Irregular Heart Beat
Anemia / Bleeding	Swelling	Infectious Diseases	Prosthetic Implant
Diabetes / Kidney	Thyroid / Hormonal	Venereal Disease	Any Transplant
Herpes	Ulcers / Digestive	Psychiatric Care	Joint Replacement
Hypoglycemia	Migraine / Headaches	TMJ	Arthritis

Please list all current medications: _____
_____

I THE UNDERSIGNED, BEING THE PATIENT OR THE PARENT OR THE GUARDIAN OF THE ABOVE MINOR PATIENT, CONSENT AFTER CONSULTATION TO THE PERFORMING OF WHATEVER PROCEDURE MAY BE DETERMINED NECESSARY BY THE DOCTOR. I AUTHORIZE AND REQUEST THE ADMINISTRATION OF SUCH DRUGS AND/OR ANESTHETICS AS DEEMED ADVISABLE BY THE DOCTOR. I ALSO UNDERSTAND THAT UPON COMPLETION OF THE ROOT CANAL THERAPY IN THIS OFFICE I WILL BE REFERRED TO MY DENTIST FOR A RESTORATION SUCH AS AN AMALGAM OR COMPOSITE FILLING OR CROWN. I CERTIFY THE ABOVE HEALTH HISTORY TO BE CORRECT. I AUTHORIZE RELEASE OF MY TREATMENT RECORD.

_____ _____
Signature Date

PATIENT INFORMATION:

Marital Status: married single widowed divorced

Place of employment: _____

Employer phone number: _____

INSURANCE COVERAGE:

self spouse dependent

SUBSCRIBER INFORMATION, IF OTHER THAN SELF:

Name: _____ Date of birth: _____

Social security number: _____ Employer: _____

EMERGENCY CONTACT:

Name: _____ Phone number: _____

Relationship to patient: _____ Alternative number: _____

AUTHORIZATION TO RELEASE INFORMATION:

Curt A. Warren, D.D.S. – Endodontics, P.C. is authorized to provide any insurance company(s), claim administrator(s), and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided.

_____ _____

Signature Date

FINANCIAL RESPONSIBILITY AGREEMENT:

In consideration of treatment rendered to the above named patient, I accept full financial responsibility. An insurance claim will be submitted electronically at completion of treatment as a convenience to the patient. **PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED**. Payment arrangements, if needed, **MUST be made prior to treatment**. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collections costs, court costs, interest of 21%, and reasonable attorney fees.

_____ (initial) **I understand that the full estimated payment is due by completion of treatment.**

_____ _____

Signature Date