Endodontics Associates
1199 Colonial Rd. Harrisburg, PA 17112
1108 E. Chocolate Ave. Hershey, PA 17033

B	<u>Patie</u>	nt Informat	<u>ion</u>				
Patient Name:	1.1		Sex: M F Birthdate:				
What name would you	like to be addres	ssed?					
Mailing address:Phone number: (h)		City:	State:	Zip:			
Phone number: (h)		_ (c)	(w) _				
Email address:							
Employer:		Оссир	ation:				
Emergency contact:			Phone numbe	r:			
Dentist's name:							
<u>P</u>	rimary Denta	l Insurance	Information				
Insurance Company:	-						
Insurance claims addre	ess:						
Policy holder's name: _			Birthdat	e:			
Employer's name:							
ID#:		Group#:					
	condary Dent	,					
Insurance Company: _	agg•						
Insurance claims addre			ع م المحادث D: معالم				
Policy holder's name: _			Birthdat	e:			
Employer's name:		Croup#.					
ID#:		Group#:		19 11			
4	ALLERGIES—	<u>please circle</u>	e YES or NO				
Penicillin	Yes No		Codeine	Yes No			
Amoxicillin	Yes No		Vicodin	Yes No			
Clindamycin			Valium	Yes No			
Erythromycin			Xanax	Yes No			
Sulfa Drugs	Yes No		Sedatives	Yes No			
Tylenol	Yes No		Steroids	Yes No			
Ibuprofen	Yes No		Novocaine	Yes No			
Aleve	Yes No		Latex	Yes No			
Aspirin	Yes No		Other				
			<del>-</del>	-			
Office Use Only:							
Medical history review	ed by:		D	ate:			

Heart disease Yes No Convulsions Yes High blood pressure Yes No Fainting spells Yes Mittral valve prolapse Yes No Migraines Yes Mittral valve prolapse Yes No Migraines Yes Heart murmur Yes No Thyroid trouble Yes Atrial fibrillation (AFib) Yes No Diabetes Yes Adangina Yes No Kidney trouble Yes Pacemaker Yes No IBS Yes Artificial heart valve Yes No IBS Yes Artificial heart valve Yes No Colitis Yes Anemia Yes No Arthritis Yes HIV/AIDS Yes No Osteoporosis Yes Blood disorder Yes No Asthma Yes Hepatitis A Yes No Lung disease Yes Hepatitis B/C Yes No Cancer Yes Herpes Yes No Radiation therapy Yes Stroke Yes No Radiation therapy Yes Stroke Yes No Psychiatric care Yes Epilepsy Yes No Joint replacement Yes Other	MEDICA	T CO	NDITION:	<u>S-please circle</u>	e YES or N	<u>O</u>		
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Is there anything else about your health we should know?				——————————————————————————————————————				
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Patient Signature (or guardian): Date:	Patient Signature (or guardian):				Date:			

### **ENDODONTICS ASSOCIATES**

#### FINANCIAL POLICY AND RELEASE OF BENEFITS

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Feel free to ask about our fees, financial policy or your responsibility.

#### **REGARDING INSURANCE**

We do not participate with any medicare plans within these groups. Copayments are due at the time treatment is rendered. We do our best to calculate your copayment as accurately as possible; however, differences can occur which may result in us sending either a bill for additional monies due or a refund if we receive a higher payment from your insurance. It is ultimately your responsibility to understand the extent and limits of your coverage. We cannot enter into disputes between you and your insurance company regarding copayments, deductibles, etc.

#### NO INSURANCE OR NON-PARTICIPATING INSURANCE

Full fee is due at the time treatment is rendered. If we do not participate with your insurance, as a courtesy we will file your claim for you to your dental insurance company; however, you must make sure to provide us with accurate information for the correct and timely filing of the claim (i.e., correct claim address, correct ID#s, etc.). If incorrect information is given it will result in the delay of reimbursement from your insurance.

\*\*\*We offer a payment discount to those patients who have no dental insurance or an insurance with which we do not participate and are responsible for the full cost of the treatment. A 5% discount is given with check or cash or a 3% discount is given with a credit or debit card. \*\*\*Discount applies only to Root Canal Therapy or Retreatment Therapy\*\*\*

We do participate with the **CareCredit** payment card, but it may only be used for amounts of \$300 or more.

#### **APPOINTMENTS**

Patients who cannot make their scheduled appointments are expected to give 24-hour notice. Broken appointments give Endodontics Associates the right to dismiss patients from the practice.

# RELEASE AND ASSIGNMENT OF BENEFITS I hereby authorize ENDODONTICS ASSOCIATES to release to the insurance company or its

representative any information including diagnosis and records of any treatment or examination rendered to me.
Signature:
I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY AND AGREE TO BE FINANCIALLY RESPONSIBLE (PAYMENTS AND/OR COPAYMENTS) FOR ANY SERVICES RENDERED.
Print Name:

Date:

Signature:

## **ENDODONTICS ASSOCIATES**

Name: Birthdate:

Social Security Number:
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
I understand by signing this consent, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. I acknowledge that I have received or have been given the opportunity to receive a copy of Endodontics Associates' Notice of Privacy Practices. I also understand I may revoke permission.
initials
CONSENT TO IMAGING
I authorize Endodontics Associates to take radiographic images, including cone beam computerized tomography (CBCT) when deemed necessary, or intra-oral photographs needed to diagnose and treat accordingly. I understand these images may be used for insurance billings/records.
initials
Signature: Date: