Endodontics Associates

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

Patient Information

Patient Name: _____ Sex: M F Birthdate: _____
What name would you like to be addressed? _____
Mailing address: _____ City: _____ State: ____ Zip: _____
Phone number: (h) _____ (c) _____ (w) _____
Email address: _____
Employer: _____ Occupation: _____
Emergency contact: _____ Phone number: _____
Dentist's name: _____

Primary Dental Insurance Information

Insurance Company: _____
Insurance claims address: _____
Policy holder's name: _____ Birthdate: _____
Employer's name: _____
ID#: _____ Group#: _____

Secondary Dental Insurance Information

Insurance Company: _____
Insurance claims address: _____
Policy holder's name: _____ Birthdate: _____
Employer's name: _____
ID#: _____ Group#: _____

ALLERGIES—please circle YES or NO

Penicillin	Yes No	Codeine	Yes No
Amoxicillin	Yes No	Vicodin	Yes No
Clindamycin	Yes No	Valium	Yes No
Erythromycin	Yes No	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 _____	

Office Use Only:
Medical history reviewed by:_____ Date:_____

MEDICAL CONDITIONS-please circle YES or NO

Heart disease	Yes	No	Convulsions	Yes	No
High blood pressure	Yes	No	Fainting spells	Yes	No
Mitral valve prolapse	Yes	No	Migraines	Yes	No
Heart murmur	Yes	No	Thyroid trouble	Yes	No
Atrial fibrillation (AFib)	Yes	No	Diabetes	Yes	No
Angina	Yes	No	Kidney trouble	Yes	No
Pacemaker	Yes	No	IBS	Yes	No
Artificial heart valve	Yes	No	Colitis	Yes	No
Anemia	Yes	No	Arthritis	Yes	No
HIV/AIDS	Yes	No	Osteoporosis	Yes	No
Blood disorder	Yes	No	Asthma	Yes	No
Hepatitis A	Yes	No	Lung disease	Yes	No
Hepatitis B/C	Yes	No	Cancer	Yes	No
Herpes	Yes	No	Radiation therapy	Yes	No
Stroke	Yes	No	Psychiatric care	Yes	No
Epilepsy	Yes	No	Joint replacement	Yes	No

Other _____

GENERAL HEALTH INFORMATION

Overall health: Excellent Good Fair Poor

Name of your family physician: _____
Have you ever had root canal therapy? Yes No
Are you taking medications at this time? Yes No
If yes, please list: _____
Have you ever been treated for substance abuse? Yes No
Do you currently premedicate with antibiotics for dental treatment due to a joint replacement, prostheses, or heart condition? Yes No
Have you ever taken a bisphosphonate (Fosamax, Actenol, or Bonvia)? Yes No
Do you take a blood thinner? Yes No
Have you been hospitalized in the past 2 years? Yes No
If so, for what? _____

Women:
Are you pregnant? Yes No if yes, how many months? _____
Are you currently taking birth control? Yes No

Is there anything else about your health we should know?

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 participate with **United Concordia, Delta Dental, Capital Blue Cross Dental and UPMC Advantage. 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: _____

Signature: _____ Date: _____

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: _____
(Patient/Guardian)