MEMPHIS ENDODONTICS

Patient Information

Patient: _____ Date of Birth: _____
Last *First* *M.I.*

Parent/Guardian (if minor): _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home: _____ Cell: _____ Email: _____

Employer: _____ Social Security No.: _____ Referred by: _____

Dental Insurance Information

Name of Insured: _____ Date of Birth: _____

Insured's Employer: _____ Insurance Company: _____

Ins.Co. Address: _____ Insured ID or Social: _____

Group #: _____ Phone #: _____

Medical History

Please check those that apply

- ☐ Heart Attack / Stroke, when? _____
- ☐ Heart Surgery, when? _____
- ☐ Pacemaker
- ☐ Heart Valve Replacement
- ☐ Heart Disease
- ☐ Shortness of Breath
- ☐ Heart Murmur/Defect
- ☐ Heart Condition
- ☐ High/Low Blood Pressure
- ☐ Organ Transplant
- ☐ Joint Replacement, when? _____
- ☐ Arthritis
- ☐ Cancer
- ☐ Radiation/Chemo
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Liver/Kidney
- ☐ Dialysis
- ☐ Tumor/Neoplasms
- ☐ Migraine/Headaches
- ☐ Glaucoma/Visual
- ☐ Infectious Diseases
- ☐ Psychiatric Care
- ☐ Depression/Anxiety
- ☐ Alcoholism/Drug Addiction
- ☐ Smoke/Tobacco
- ☐ Venereal Disease
- ☐ HIV/AIDS/Hepatitis
- ☐ Ulcers/Digestive
- ☐ Immunocompromised
- ☐ Systemic Lupus
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Lung Disease
- ☐ Respiratory/Asthma
- ☐ TMJ/Jaw
- ☐ Anemia/Bleeding
- ☐ Epilepsy/Fainting
- ☐ Bisphosphonate Therapy (Fosamax, Actonel, Boniva, Reclast, etc.)
- ☐ Injury to face, jaws or teeth
- ☐ Sinus Problems
- Pregnant/Nursing Due: _____
- ☐ Other _____

Are you currently taking any medication? If YES, what and why? _____

_____

Have you been hospitalized this year for any illness?

If YES, why? _____

Physician's Name _____

ARE YOU ALLERGIC TO OR HAVE HAD HIVES OR ITCHING FROM ANY OF THE FOLLOWING?

Please check those that apply

- ☐ Penicillin
- ☐ Clindamycin
- ☐ Codeine
- ☐ Local Anesthetic/ Epinephrine
- ☐ Antibiotics
- ☐ Narcotics
- ☐ Latex
- ☐ Nitrous
- ☐ Sulfite/Sulfa
- ☐ Other_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

I, _____, have received a copy of this office's Notice of Privacy Practices.
(Print Name)

Signature_____ **Date**_____

OFFICE POLICY

1. The purpose of root canal therapy is to retain teeth that would otherwise have to be extracted.
2. Successful treatment occurs in 90% of cases. The doctor will advise you if chances in your particular case are lower. The treatment, as with any medical or dental treatment, has no guarantees of success for any length of time.
3. **The Endodontist's fee includes only Endodontic treatment and upon completion of this you will be referred back to your family dentist so that he may restore the treated tooth with a durable filling, inlay or crown.**
4. Root canal therapy is slow and tedious work – delays may occur. This office handles complicated cases and numerous emergencies many times each day. Appointments are subject to delay. We apologize for the delays. If you are an emergency or work-in patient, this is not an appointment time. Delays may exceed an hour. Please check with the receptionist about delays.

ENDODONTIC FEES

Fees vary with complexity of each case. Please contact our office for a **cost estimation**.

I have read and fully understand the statement of this office policy. I realize that the final restoration of any tooth treated in this office must be completed by the family dentist. I am aware that there is no guarantee of success for any treatment rendered in this office.

I consent to the performance of whatever procedures may be deemed necessary or advisable in the opinion of the doctor for the Endodontic treatment of tooth (teeth).

We provide insurance company billing as a courtesy to our patients. The patient portion of your dental services are estimated and due at the time of service. This amount may be subject to change when the dental service claims are adjudicated by the insurance company. Please understand this is only an **estimate** and you are responsible for any charges not covered by your insurance.

Root canal treatment fees are payable in full the day of service. I assign insurance benefits to Memphis Endodontics, PLC in the event my account is turned over to collections. I agree to pay 33 1/3 percent attorney's fees plus any and all collection fees.

I further agree to assume full responsibility for the fee quoted to me for the treatment rendered.

The payment selected is: (Please select one)

- ☐ **Cash or Check**
- ☐ **Visa, Master Card, Discover or American Express**
- ☐ **CareCredit (6 months deferred interest)**

Signature_____ **Date**_____