PATIENT INFORMATION

PLEASE PRINT

Kensington Valley Endodontics, PC

LAST NAME - FIRST NAME - INITIAL	TITLE	SOC. SEC. NO.	BIRTHDATE	AGE

ADDRESS	CITY, STATE	ZIP CODE	Sex
			Male Female

FAMILY DENTIST	YOUR HOME PHONE	YOUR WORK PHONE	MARITAL STATUS	SPOUSE'S NAME

FAMILY PHYSICIAN	YOUR OCCUPATION	YOUR EMPLOYER

PRIMARY INSURANCE INFORMATION AND/OR LEGAL GUARDIAN OF PATIENT

PLEASE PRINT INSURED'S INFORMATION

LAST NAME - FIRST NAME - INITIAL	RELATION	SOC. SEC. NO.	BIRTHDATE

INSURANCE COMPANY NAME	INSURANCE CO TELEPHONE #	GROUP NUMBER

INSURANCE COMPANY ADDRESS	CITY, STATE	ZIP CODE	INSURED'S EMPLOYER

SECONDARY INSURANCE INFORMATION

PLEASE PRINT INSURED'S INFORMATION

LAST NAME - FIRST NAME - INITIAL	RELATION	SOC. SEC. NO.	BIRTHDATE

INSURANCE COMPANY NAME	INSURANCE CO TELEPHONE #	GROUP NUMBER

INSURANCE COMPANY ADDRESS	CITY, STATE	ZIP CODE	INSURED'S EMPLOYER

In the event of an emergency, is there someone who lives near you that we should contact?

Name _____ Relation_____ Home #_____ Work #_____

Payment and Insurance Policy

Dental insurance is a contract between your employer and an insurance company. The benefits you will receive are based on the terms negotiated between your employer and your dental insurance company and not this endodontic office. We will **estimate** your co-payment to the best of our ability. As a patient you are responsible for all fees incurred at our office. We will submit claims for services rendered to your insurance carrier; however, any unpaid insurance balances are your responsibility and are due 45 days after the date of treatment. A binding arrangement for payment is necessary at the first appointment. Please indicate your method of payment below.

CASH ___ CHARGE/DEBIT CARD ___ CHECK ___ Payment Plan* ___

*Requires Approval

Agreement to Pay for Services Rendered

I have reviewed the above payment options and fees. I agree to be responsible for all charges for dental services. I authorize release of any information relating to this agreement for the purpose of insurance or collection. I acknowledge that fees and co-pays quoted to me prior to treatment are estimates only, and the final amount charged to me or my insurance company may differ from the initial estimate. I have read, understand, and agree to the Payment and Insurance Policy detailed above. I authorize subsequent charges to the credit card or debit card I used for my co-payment for any unpaid account balances. I authorize subsequent charges to the Care Credit account I used for my co-payment for any unpaid account balances. I acknowledge these authorizations to be final and irrevocable.

_____ _____

Signature (Patient or parent if minor) Date

Name:		
Are you currently under a physician's care?		Your overall health is (circle one): Good Fair Poor
Women:	Do you take birth control pills?_____ Are you nursing?_____ Are you pregnant? _____ Month? ____	

List all medications that you are taking

_____

_____

_____

_____

Circle items to which you have reactions or allergies

penicillin aspirin local anesthetic codeine
clindamycin ibuprofen latex

List others: _____

_____

Do you normally take antibiotics before your dental appointments?

Circle any of the following you have or have had

heart trouble
prosthetic heart valves
angina
pacemaker
prolonged bleeding
stroke
high blood pressure
heart attack
bacteremia
blood disorders
prosthetic joints
radiation therapy
Auto-immune disorders
intestinal problems
kidney trouble
liver problems
diabetes
chemical dependence
asthma
auto-immune disorders
respiratory disease
tuberculosis
epilepsy
hepatitis
IV drug use
AIDS / HIV Positive
fibromyalgia

Do you have any medical conditions not listed above?

If yes, please explain:

_____

_____

_____

Is this treatment a result of an injury or accident?

If yes, please explain:

_____

_____

_____

Osteoporosis, Paget's Disease, Multiple Myeloma, and Bisphosphonates

Are you currently taking or have you taken bisphosphonate medications within the past twelve years? YES NO (circle one)

If so, please describe which medications and for how long you have been or did take each medication.

Orally Administered Bisphosphonates:	# of years taken	If discontinued, in what year?
Fosamax (Alendronate)		
Boniva (Ibandronate)		
Actonel (Risedronate)		
Skelid (Tiludronate)		
Olpadronte		
Didronel, Didrocal (Etidronate)		
IV Administered Bisphosphonates		
Zometa, Reclast, Aclasta (Zoledronic Acid)		
Bonefos, Clasteon, Ostac (Clodronate)		
Aredia (Pamidronate)		
Nerixia (Neridromate)		

I understand that the information I have given today is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment. I understand that treatment is no guarantee of success and that complications which may result in tooth loss or necessitate further treatment may occur. I also understand that I am to return to my dentist for permanent restoration of the treated tooth within 6 weeks.

Signature (patient or guardian) _____ Date _____

OFFICE USE ONLY

I have reviewed the information above with the patient _____

NOTES:

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