Welcome to Fairfield Endodontics

Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's date: _____ ☐Male ☐Female

Name: _____
Last First MI Mr Mrs Ms Dr

Birth date: _____ SS#: _____

Home Address: _____
Apt/Condo

_____
City State Zip

Home #: _____ Cell #: _____

Wk #: _____ Ext: _____

E-Mail Address: _____

Employer: _____

Employer's Address: _____

When & where is best to reach you? _____

Referred by: _____

General Dentist: _____

Dental Insurance

Primary Insurance Co. _____

Ins. Co. Address: _____

Ins. Co. Phone #: _____

Insured's Name: _____

Relation: _____ Birth date: _____

ID#: _____Group#_____

Employer: _____

Secondary Insurance Co. _____

Ins Co. Address: _____

Ins. Co. Phone #: _____

Insured's Name: _____

Relation: _____ Birth date: _____

ID #: _____Group #_____

Employer: _____

Person Responsible for account: _____

Relation: _____ Phone #: _____

Billing Address: _____

_____

Medical & Dental History

Reason for visit: _____

Are you under the care of a physician? ☐ Yes ☐ No

Please Explain: _____

_____

Physician's name: _____

Phone #: _____ Date of last visit: _____

Are you taking medications regularly? ☐ Yes ☐ No

Please list each one: _____

_____

Please list any hospitalizations: _____

_____

For women: Are you taking birth control pills? ☐Yes ☐No
Are you pregnant? ☐ Yes ☐ No Week #: _____
Are you nursing? ☐ Yes ☐ No

Please check (√) if you have ever had a history of any of the following conditions:

☐ Abnormal bleeding
☐ Anemia
☐ Artificial bones/joint/valves
☐ Angina/Chest Pain
☐ Heart Disease
☐ Stroke
☐ Ulcers
☐ Tumor/Cancer
☐ Tuberculosis
☐ Hay Fever
☐ Hives
☐ Thyroid Disease
☐ Cortisone Medication
☐ Pain in Jaw joints/TMJ
☐ Blood Transfusion
☐ Lupus
☐ Fainting/Dizzy Spells
☐ Sickle Cell Disease
☐ Liver Disease
☐ Drug Abuse/Alcoholism
☐ Persistent Cough
☐ Hemophilia
☐ Hepatitis
☐ High/Low blood pressure
☐ Heart Surgery
☐ Heart Attack
☐ Kidney Trouble
☐ Shortness of Breath
☐Radiation/Chemotherapy
☐ Asthma
☐ Sinus Trouble
☐ Diabetes
☐ Arthritis/Rheumatism
☐ Glaucoma
☐ Bruise Easily
☐ Venereal Disease
☐ Epilepsy/Seizures
☐ Psychiatric Treatment
☐ Emphysema
☐ Jaundice
☐ HIV/AIDS

Please list if you have a condition/disease not listed:

_____

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Continued

Are you allergic to any of the following?

Aspirin ☐yes ☐no Local Anesthetic ☐yes ☐no
Penicillin ☐yes ☐no Erythromycin ☐yes ☐no
Codeine ☐yes ☐no Tetracycline ☐ yes ☐no
Doxycycline ☐yes ☐no Metals/plastics ☐yes ☐no
Latex ☐yes ☐no Other ☐yes ☐no

Please list any other drugs/materials that you are allergic to: _____

In the event of an emergency, who should we contact?

Name: _____ Relation: _____
Hm #: _____ Wk #: _____

Please add anything to this history you feel is important for us to know: _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____ _____
Signature Date Relation (if other than patient)

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), day to day healthcare operations of your practice and obtain payment from third party payers.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____ _____
Signature Date Relation

OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY

Medical History reviewed by: _____ Date: _____
Medical History updates:

Date	Update	Dr's Initials