FAIRFIELD ENDODONTICS, PC

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT NAME (FIRST, LAST, MI) ◯ **MR.** ◯ **MRS.** ◯ **MS.** ◯ **DR.** ◯ **MALE** ◯ **FEMALE**

SOCIAL SECURITY NUMBER: **Birthdate:**

Home Address **City** **State** **Zip** **E-mail Address**

Phone Number(s) Home: ____________________
Cell: ____________________
Work: ____________________

How would you prefer to be contacted? ◯ **Phone** ◯ **Email**

DENTAL INSURANCE

PRIMARY INSURANCE COMPANY **Group Number** **Subscriber ID**

Employer **Policy Holder/Relation** **Birthdate**

SECONDARY INSURANCE INFORMATION **Group Number** **Subscriber ID**

RESPONSIBLE PARTY (If the person responsible for this account is different from the patient or if the patient is a minor)

Name **Social Security Number** **Birthdate**

Home Address **City** **State** **Zip** **Phone Number**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Fairfield Endodontics, PC's Notice of Privacy Practices.

Patient or Guardian Signature: ____

FOR OFFICE USE ONLY – We attempted to obtain written acknowledgement of receipt of or Notice of Privacy Practices, but acknowledgement could not be obtained because: ◯ individual refused to sign. ◯ Communication barriers prohibited obtaining the acknowledgement. ◯ An emergency situation prevented us from obtaining acknowledgement. ◯ Other (please specify)

Print Name: **Today's Date:**

DENTAL HISTORY

REASON FOR TODAY'S VISIT

General Dentist **Last Visit**

Are you nervous about seeing a dentist? ◯ **Yes!** ◯ **No** **(If yes, please tell us why)**

MEDICAL HISTORY

I consider my health to be:	◯Excellent	◯ Good	◯ Fair	◯ Poor
Physician's Name:		**Date of Last Visit:**		

Please check off if you have ever had a history of any of the following conditions:

◯Abnormal Bleeding
◯Anemia
◯Artificial bones/joints/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 Type ______
◯High/Low Blood Pressure

◯Heart Surgery
◯Heart Attack
◯Kidney Trouble
◯Shortness of breath
◯Radiation/Chemotherapy
◯Asthma
◯Sinus Trouble
◯Diabetes
◯Arthritis/Rheumatism
◯Glaucoma
◯Bruise Easily
◯STD/Venereal Disease

◯Epilepsy/Seizures
◯Psychiatric Treatment
◯Emphysema
◯Jaundice
◯HIV/AIDS

WOMEN

Are you taking birth control medication? ◯Yes ◯No

Are you pregnant or nursing? ◯Yes ◯ No

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

Please list any hospitalizations:

Please list all medications you are currently taking:

Please check off all allergies that apply:

◯Aspirin ◯Local Anesthetic
◯Penicillin ◯Erythromycin
◯Codeine ◯Tetracycline
◯Metals/plastics ◯ Latex

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

Please add anything to this history you feel is important:

____

____

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

Name:____________________________

Relation:__________________________

Phone Number:____________________

TERMS AND CONDITIONS

I understand that the information 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.

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

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. I have read the above conditions and agree to their content.

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

Important: Save the completed PDF form (use menu File - Save).
Please print this form and bring into the office.

Medical History reviewed by:___________________ Date:____________