

Last Name	Middle Initial	Sex		Birth Date		Social Security #	
First Name		M	F	/	/	-	-

Home Street Address		
City	State	Zip
Home Phone () -		Cell Phone () -
Work Number () -		Alternate Phone Number () -

(Numbers listed will be used, if you would not like us to call a certain number, please notate it above)

EMERGENCY CONTACT

Name	Relationship
Phone Number () -	Alternate Phone Number () -

Please provide us with your dentist's name, address and phone number so that we may supply them with records of your dental treatment.

Referring Dentist	Phone () -	
Address		
City	State	Zip

DENTAL INSURANCE INFORMATION

Primary Insurance Company	Employer
Subscriber Name	Subscriber Social Security # - -
Group Policy #	
Relationship To Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian	
Secondary Insurance Company (if any)	Employer
Subscriber Name	Subscriber Social Security # - -
Group Policy #	
Relationship To Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian	

Medical History

Please complete the following questions so we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

Name of Physician _____	Phone () -	
Please Check and Name the Medications You Are Taking:		
<input type="checkbox"/> No Medications _____	<input type="checkbox"/> Hormone _____	
<input type="checkbox"/> Antibiotics _____	<input type="checkbox"/> Thyroid _____	
<input type="checkbox"/> Pain Medicine _____	<input type="checkbox"/> Birth Control Pills _____	
<input type="checkbox"/> Heart Medicine _____	<input type="checkbox"/> Insulin _____	
<input type="checkbox"/> Aspirin _____	<input type="checkbox"/> Ulcer/Nexium _____	
<input type="checkbox"/> Cortisone/Steroids _____	<input type="checkbox"/> Bone Related _____	
<input type="checkbox"/> Blood Thinner _____	<input type="checkbox"/> Antidepressants _____	
<input type="checkbox"/> Blood Pressure _____		
If you are taking any additional medications please list them below		
1. _____	2. _____	3. _____
4. _____	5. _____	6. _____
7. _____	8. _____	9. _____
Have you ever had any ALLERGIC OR ADVERSE reactions to anesthetics, antibiotics, latex or other medications? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please describe:		
Please Check any Allergies you have:		
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Narcotics	<input type="checkbox"/> Food
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Local Anesthesia	<input type="checkbox"/> Bleach
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Latex	<input type="checkbox"/> Iodine/Seafood
<input type="checkbox"/> Tylenol	<input type="checkbox"/> Valium/Tranquil.	
<input type="checkbox"/> Codeine	<input type="checkbox"/> Nitrous	
If you have any additional ALLERGIES, please list them below		

Have you had, or do you presently have any of the following conditions? (Please check all that apply)

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Ulcers/Digestive	<input type="checkbox"/> TMJ
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Smoker	<input type="checkbox"/> Migraine/Headaches	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Respiratory/Asthma	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Epilepsy/Fainting	<input type="checkbox"/> Heart Murmur/Defect
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma/Visual	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Hypertension/Circula	<input type="checkbox"/> Radiation/Chemo	<input type="checkbox"/> Mental/Neural	<input type="checkbox"/> Heart Attack/Stroke
<input type="checkbox"/> Immunocomprised	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumor/Neoplasm	<input type="checkbox"/> Irregular Heart Beat
<input type="checkbox"/> Anemia/Bleeding	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Alcoholism/Addiction	<input type="checkbox"/> Prosthetic Implant
<input type="checkbox"/> Diabetes/Kidney	<input type="checkbox"/> Swelling	<input type="checkbox"/> Infections Diseases	<input type="checkbox"/> Any Transplant
<input type="checkbox"/> Herpes	<input type="checkbox"/> Overweight	<input type="checkbox"/> Venereal Diseases	<input type="checkbox"/> Joint Replacement
<input type="checkbox"/> Thyroid/Hormonal	<input type="checkbox"/> Underweight	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Seizures	<input type="checkbox"/> STD	<input type="checkbox"/> Hepatitis/Jaundice/Liver

1. Do you have any disease, condition, or problem not previously listed? Yes No
If YES, please explain: _____

2. Have there been ANY changes in your general health within the past year? Yes No
3. Are you currently under the care of a Physician for a current Problem? Yes No
Nature of Treatment: _____
4. Have you been hospitalized within the past five years? Yes No
Reason: _____
5. Have you had abnormal bleeding with previous extractions, surgery or trauma? Yes No
6. Have you ever been tested for HIV infection (AIDS)? Yes No
Result of test: PositiveNegative
7. Are you currently taking or have you taken any bisphosphonate medications, (e.g. Didronel, Aredia, Fosamax, Actonel, Zometa, Boniva, etc.) within the past Five years? Yes No
8. **Are you required to take antibiotics prior to ALL dental treatment?** Yes No

WOMEN ONLY

- Are you Pregnant? Yes No If Yes, How many months? _____
- Are You Breastfeeding? Yes No
- Are you Taking Birth Control Pills? Yes No

If you are taking birth control pills, please read the following Antibiotics may decrease the effectiveness of birth control medications. Therefore, if you are prescribed antibiotics during endodontic treatment, additional birth control methods should be used until your next menses.

ALL of the above information is true to the best of my knowledge. I understand that ALL fees are due on the date in which services are rendered. Should this matter be turned over for collection, all costs, including reasonable collection fees and court costs incurred by Surprise and Desert Sun Endodontics shall be borne by the undersigned.

Signed: _____ Date: _____
(Patient or Guardian)

Signed: _____ Date: _____
(Treating Dentist)

Last Name:	First Name:	DOB:
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Welcome to Surprise and Desert Sun Endodontics. Dr. Jason Booth, Dr. Frank Castano and the staff are very happy that you chose our office for your endodontic needs. Below is our complete financial policy. Should you need clarification or have any questions, please feel free to ask the front desk as we are here to help you understand the fees associated with your specific treatment plan as well as the insurance process.

Payments & Fees:

Endodontic treatment fees without insurance can **range** depending upon the treatment required. Suitable arrangement for payment needs to be made prior to the time of treatment.

While payment for services is due at or before the time services are rendered, we offer several, flexible payment options. We accept cash, checks, Visa, MasterCard, Discover, and American Express. If needed, we are also happy to offer a 0% interest financing option through a company called Care Credit. -A \$35.00 returned check fee will be charged for any check that is returned by your bank.

Patients with Dental Insurance:

If you have Dental Insurance, we are happy to help you receive your maximum allowable benefits by filing your insurance claims for you. We ask that you provide us with all your insurance information at the time you schedule your appointment. We will then contact your insurance carrier to find your specific plan’s insurance benefits, and let you know your **estimated** portion prior to your appointment. Since insurance policies vary, we can only **ESTIMATE** your coverage, please be advised that an estimate provided **does not guarantee coverage**. While we try our best to estimate your out-of-pocket expense, actual payment is determined by the insurance company once they process the claim. Please know that filing an insurance claim does not relieve you of **responsibility for your bill**. Most insurance companies remit payment to our office within four to six weeks. Any remaining balances after your insurance has paid, is your responsibility. Surprise and Desert Sun Endodontics are not responsible for any coverage denials by dental plans. **We require co-pays, deductibles, and your estimated portion to be made at the time services are rendered.**

We will wait 90 days for the insurance company to pay their portion. In the event your insurance company fails to pay, rejects the claim, or does not pay the total balance, **you are responsible** for the remaining balance.

Remaining balances **AFTER** insurance has paid are due and payable at that time. Unpaid balances after 30 days will be charged a \$25 late fee and are subject to interest. Remaining balances **AFTER** 90 days will be forward to a third party collection agency at an increased rate of 37%. You will be responsible for all collection fees and attorney fees in conjunction with collecting the balance due on your account.

Patients without Dental Insurance:

For those patients without dental insurance we require **payment in full** at the time of service. We do offer 0% financing through a company called Care Credit. Applications can be filled out online or over the phone. For example, we have available a finance plan through Care Credit that will enable you to make monthly payments for up to eighteen months interest free. If you would like more information about Care Credit, please feel free to ask our knowledgeable staff.

Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage.

Printed Patient (or) Guardian Name	Signature	Date
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this acknowledgement *

I, _____, have received a copy of Surprise and/or Desert Sun Endodontic's Notice of Privacy Practices.

I hereby permit Surprise and/or Desert Sun Endodontics to use my health information, and/or to disclose my health information to any third party payer, or to any party involved in my health care.

This consent shall be in force and in effect as long as I am a patient in this practice.

I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to Surprise and/or Desert Sun Endodontics.

I understand that information used or disclosed pursuant to this consent may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____ (PRINT name)

_____ (Signature)

_____ (Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Other:

