ENDODONTIC
EAST ALABAMA associates
Root Canal Specialists

PLEASE PRINT

PATIENT'S NAME: ______________________ EMAIL ADDRESS: ____________________
DATE OF BIRTH__________ SS#: ______________ GENDER: ☐ MALE ☐ FEMALE
ADDRESS: ____
CITY: ______________________ STATE: ________ ZIPCODE: __________
HOME PHONE:____________CELL PHONE:________________WORK PHONE: ________
OCCUPATION:__________________EMPLOYERS NAME: ________________________
SPOUSE/ PARENT/ GUARDIAN NAME: ______________________________________
PARENT/ GUARDIAN ADDRESS: ____
CITY: ______________________ STATE: ________ ZIPCODE: __________
REFERRED BY:______________________GENERAL DENTIST: ____________________

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MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Please check if YES)

☐ HEART DISEASE/ATTACK
☐ HEART MURMUR
☐ HEART SURGERY
☐ PACEMAKER
☐ MITRAL VALVE PROLAPSE DISORDERS
☐ RHEUMATIC FEVER
☐ RHEUMATIC HEART DISEASE
☐ STROKE
☐ PROSTHETIC HEART VALVE
☐ ANGINA PROBLEMS
☐ CONGENITAL HEART DEFECT
☐ OTHER HEART CONDITIONS
____
____
☐ HIGH BLOOD PRESSURE
☐ TUBERCULOSIS
☐ EMPHYSEMA
☐ ASTHMA
☐ SINUS PROBLEMS/ALLERGIES
☐ HEPATITIS – TYPE: A B or C
☐ JOINT REPLACEMENT
☐ PARKINSON'S DISEASE
☐ SURGERY IN THE PAST YEAR
DATE: ________________

☐ STOMACH ULCERS
☐ DIABETES
☐ MRSA
☐ STAPH
☐ THYROID
☐ STEROID THERAPY
☐ EPILEPSY
☐ FAINTING/SEIZURES
☐ BLOOD TRANSFUSION
☐ BLEEDING PROBLEMS
☐ ANTICOAGULANTS (BLOOD THINNERS)
☐ ANEMIA (LOW BLOOD)
☐ LEUKEMIA
☐ HEARING IMPAIRED
☐ LIVER DISEASE
☐ TMJ PROBLEMS
☐ CANCER/TUMOR
☐ VENEREAL DISEASE
☐ HIV POSITIVE
☐ AIDS
☐ DRUG DEPENDENCY

ARE YOU TAKING ANY MEDICATIONS? ☐ YES ☐ NO
PLEASE LIST YOUR MEDICATIONS:
____
____
____
DO YOU PREMEDICATE WITH ANTIBIOTICS BEFORE DENTAL PROCEDURES DUE TO ARTIFICIAL JOINT? ☐ YES ☐ NO
IF YES, NAME OF ANTIBIOTIC ______________
ARE YOU ALLERGIC TO:
☐ ASPIRIN ☐ PENICILLIN ☐ LATEX ☐ SULFA
☐ CODEINE ☐ IBUPROFEN ☐ LOCAL ANESTHETIC
OTHERS (Please list): ____________________
____
ARE YOU PREGNANT?☐ YES ☐ NO
ARE YOU UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO
(If YES, please list reason and physician's name)
____
DO YOU WANT NITROUS OXIDE (LAUGHING GAS)? ☐ YES ☐ NO (Your insurance may not cover this)

TOOTH HISTORY

ARE YOU CURRENTLY IN PAIN? ☐ YES ☐ NO
IF YES, PLEASE RATE THE DISCOMFORT (1=slight & 10=unbearable) _____/ 10
THE TOOTH IS SENSITIVE TO: ☐ TEMPERATURE ☐ PRESSURE ☐ BITING ☐ OTHER: ____________
DO YOU HAVE OR HAVE YOU HAD SWELLING OR DRAINAGE? ☐ YES ☐ NO
COMMENTS: ______________________________
____

REASON: ____

____

OTHER MEDICAL CONDITIONS/CONCERNS: _______

PATIENT FINANCIAL AGREEMENT & RELEASE OF INFORMATION

The following is a statement of the Practice's financial policies, which you must read and agree to prior to any treatment.

1. PAYMENT. Payment of any unmet deductible, co-insurance, co-payment, and any charges not covered by insurance is expected at the time of your visit. We accept cash, check and major credit cards. In addition, we may have additional financing options available to you on or after your initial date of service.

2. INSURANCE, DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE

- It is your responsibility to confirm which treatments or procedures are covered and/or paid by insurance (including, but not limited to, any applicable exclusions, deductibles, and annual or lifetime maximums) & any referrals required by your insurance.
- As a courtesy, we will file your insurance claim for you; however, please remember that insurance is NOT a guarantee of payment. In order to bill your insurance and to meet filing guidelines, we require a copy of your insurance card and a photo ID.
- We can only approximate the percentage covered by each plan. Payment of the ESTIMATED portion as well as your co-payment is due at time of service.
- Any estimate of insurance coverage may differ from what your insurance carrier ultimately pays. You will be responsible for any charge that insurance determines to be not covered.
- **NOTE: If your doctor has recommended General Anesthesia, this does NOT mean your insurance will consider this to be a "Medically Necessary" procedure and pay for this service
- As the parent or guardian accompanying a minor, you are financially responsible for all charges, whether or not paid by insurance.
- In situations of divorce, separation, court orders, etc., the adult who signs in a minor child on the day of treatment accepts financial responsibility for payment.
- Non-covered procedures will not be filed to insurance.
- Medicare does not cover in-office general anesthesia or dental related procedures including extractions.
- Adults 21 years of age and older are not eligible for dental coverage through Medicaid.
- Private pay/uninsured patients must pay in full at time of service.

3. BILLING AND COLLECTION

- Returned checks will be subject to a fee of up to $30.00, except where prohibited by law.
- Payment is due as stated on any billing statement mailed, emailed or otherwise delivered to you. If we do not receive payment within fifteen (15) days of the due date, your account shall be past-due.
- Interest at the maximum rate amount allowed by law will be charged on all past due accounts.
- Past due accounts may be placed with a collection agency or attorney for collection.
- In addition to the charges for services and treatment received, you agree to be responsible for and to pay all costs and expenses incurred in the collection of amounts past due on your account including, but not limited to, collection agency fees, reasonable attorney's fees and expenses, collection expenses, and court costs.
- If your account is turned over for collections, you will no longer be able to receive services from the Practice until your delinquency is cured.

4. CONSENT TO CONTACT. The Practice may contact you for any purpose and in any manner permitted by law. You also expressly consent to be contacted by the Practice, and anyone contacting you on our behalf, for any purpose, including billing, collection, or other account or service-related purpose, at any telephone number or physical or electronic address where you may be reached, including any wireless telephone number. We may contact you in any way, such as calling, texting, emailing, sending mobile application push notifications, or using any other method of communication permitted by law. You agree that the Practice, and anyone contacting you on our behalf, may communicate with you in any manner, including through the use of an artificial or pre-recorded voice message or an automatic telephone dialing system. We may contact you on a mobile, wireless, or similar device, even if you are charged for it.

I have read the financial policies above, and my signature below indicates my agreement to these policies and acceptance of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for any services provided to me, I assume financial responsibility and will pay all such charges in full.

I hereby authorize the Practice to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the Practice all insurance benefits otherwise payable to me for the Practice's services.

______________________________   ______/______/______

Patient Name   Patient DOB

______________________________   ______________

Patient or Responsible Party Signature   Date

______________________________   ______________

Printed Name of Responsible Party (if applicable)   Relationship to Patient (if applicable)