PRECISION ENDODONTICS OF WAYNE, P.C.

Welcome To Our Practice

NEW PATIENT FORM FOR ROOT CANAL TREATMENT

□ Mr. □ Mrs. □ Ms. □ Dr. First Name_____ M.I._____ Last Name_____ Nickname_____

Sex: □ Male □ Female Birth Date_____ Age_____ S.S. #_____

Street_____ City_____ State _____ Zip _____

Home Tel. _____ Cell # _____ E-mail _____

Emergency Contact _____ Tel. _____

Referring Dentist_____ Medical doctor_____ Ph. #_____

Employer's Name_____ Work Tel._____

Who will be responsible for your account? □ Self □ Spouse □ Parent □ Other ***(if Self, skip to the next section)***

Name_____Relation _____Birth Date_____S.S. #_____

Street_____ City _____ State_____ Zip_____

Tel. (____) _____

Personal Payment Type: □ Cash □ Check □ Credit Card □ CareCredit

PRIMARY DENTAL INSURANCE COMPANY

Employer_____

Bus. Tel. (___) _____

Insurance Co. Name_____

Ins. Address _____

_____Tel. (___) _____

Group #_____Plan Name_____

Ins. Policy holder_____ Sex: □ M □ F

Insured's DOB_____ Insured's S.S. #_____

Subscriber ID_____

SECONDARY DENTAL INSURANCE COMPANY

Employer_____

Bus. Tel. (___) _____

Insurance Co. Name_____

Ins. Address_____

_____Tel. (___) _____

Group #_____Plan Name_____

Ins. Policy holder_____ Sex: □ M □ F

Insured's DOB_____Insured's S.S. _____

Subscriber ID_____

DENTAL INFORMATION

Reason for today's visit: □ Exam/Consult □ Emergency □ Root Canal □ Second opinion Are you in pain? □ Yes How long? _____ □No

Please indicate any of the following problems by checking off the corresponding box:

My teeth are sensitive to: □ Hot □ Cold □ Sweets □ Biting

□ Lost/broken filling(s)

□ Toothache

□ TMJ

□ Locking Jaw

□ Grind/clench teeth

□ Swelling/lump(s) in mouth

□ Food caught between teeth

(over)

Patient's Name: _____

MEDICAL HISTORY

Have you had any illness, operation, or been hospitalized in the past five years? ☐ Yes ☐ No Why? _____
Do you have or have had any of the following diseases, medical conditions or procedures? If yes, when?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Rheumatic Fever	☐	☐	Asthma/Respiratory problems	☐	☐	Bruise easily	☐	☐	Tuberculosis
☐	☐	Mitral valve	☐	☐	Sinus Problems	☐	☐	Delay Healing	☐	☐	Hepatitis
☐	☐	Heart murmur/stents	☐	☐	Stroke	☐	☐	Thyroid Trouble	☐	☐	HIV/Aids
☐	☐	Heart Attack	☐	☐	Blood Disorder	☐	☐	Kidney Trouble	☐	☐	Radiation / Chemotherapy
☐	☐	Cardiac Pacemaker	☐	☐	Abnormal Bleeding	☐	☐	Stomach Ulcer	☐	☐	In Dialysis Treatment
☐	☐	Heart Surgery	☐	☐	Bleeding Tendency	☐	☐	History of Alcohol abuse	☐	☐	Joint Replacement
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	History of Drug abuse	☐	☐	Osteoporosis
☐	☐	Low Blood Pressure	☐	☐	Low Blood Sugar	☐	☐	Contagious Diseases	☐	☐	Other: _____

MEDICATION AND ALLERGIES

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Antibiotics	☐	☐	Pain Medication (Advil, Tylenol)	☐	☐	Muscle relaxers	☐	☐	Antidepressants
☐	☐	Blood thinners (Coumadin, Aspirin, etc.)	☐	☐	Insulin	☐	☐	Tranquilizers			

Please list any other medication(s) you are currently taking:

_____

_____

Are you allergic to or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Penicillin, Amoxicillin	☐	☐	Sulfa drugs	☐	☐	Local Anesthetic (numbing med)	☐	☐	Latex
☐	☐	Valium or other tranquilizers	☐	☐	Aspirin	☐	☐	Codeine or other narcotics	☐	☐	Other

Please list any other medication(s) or antibiotic you are allergic to:

_____

_____

Please list any allergies other than drug allergies:

_____

_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient: ***(Parent or Guardian if minor)*** **Date** **Reviewed by:**

Questions 1-4 below for women only): ***(women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your Physician/gynecologist for assistance regarding additional methods of birth control.)***

1) Is there a possibility of pregnancy? ☐ Yes ☐ No 2) Expected delivery date: _____
3) Are you nursing? ☐ Yes ☐ No 4) Are you taking birth control pills? ☐ Yes ☐ No

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office staff depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental insurance, we will be glad to assist you in filing a claim but please complete the identifying patient information on this form.

It is your responsibility to cover any outstanding balance or any other balance not paid for by your insurance company. In the event your account requires collection effort, you agree to be responsible for any court costs, attorney fees and collection costs at a rate of up to 32% of your outstanding balance.

Signature of Patient: _____ **Date:** _____
(Parent or Guardian if minor)

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of Patient: _____ **Date:** _____
(Parent or Guardian if minor)