SURPRISE ENDODONTICS

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

Home Street Address (REQUIRED)		
City	State	Zip
Home Phone # ( ) -	Cell Phone # ( ) -	
Email:		
Emergency Contact Name	Phone # ( ) -	

Referring Dentist Name:	Phone Number ( ) -
Practice Name:	Cross-Streets:

Dental Insurance Company	Employer
Subscriber Name	Member ID#
Group Policy #	
Relationship To Patient ☐ Self ☐ Spouse ☐ Parent/Guardian	

MEDICAL HISTORY

ALLERGIES

Have you ever had any **ALLERGIC** OR **ADVERSE** reactions to anesthetics, antibiotics, latex or other medications? ☐ YES ☐ NO If YES, please describe:

Please Check any Allergies you have:

☐ Penicillin	☐ Narcotics	☐ Food
☐ Antibiotics	☐ Local Anesthesia	☐ Bleach
☐ Aspirin	☐ Latex	☐ Iodine/Seafood
☐ Tylenol	☐ Valium/Tranquil.	
☐ Codeine	☐ Nitrous	

If you have any additional ALLERGIES, please list them below

WOMEN ONLY

Are you Pregnant? ☐ Yes ☐ No If Yes, How many months? _____

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.

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

☐ **High Blood Pressure**	☐ **Hypoglycemia**	☐ **Ulcers/Digestive**	☐ **Liver Disease**
☐ **Low Blood Pressure**	☐ **Sinus Trouble**	☐ **Migraine/Headaches**	☐ **Heart Disease**
☐ **Respiratory/Asthma**	☐ **Shortness of Breath**	☐ **Epilepsy/Fainting**	☐ **Heart Murmur/Defect**
☐ **Rheumatic Fever**	☐ **Cancer**	☐ **Glaucoma/Visual**	☐ **Pacemaker**
☐ **Hepatitis**	☐ **Radiation/Chemo**	☐ **Mental/Neural**	☐ **Heart Attack/Stroke**
☐ **Immunocompromised**	☐ **Tuberculosis**	☐ **Tumor/Neoplasm**	☐ **Irregular Heartbeat**
☐ **Anemia/Bleeding**	☐ **Fatigue**	☐ **STD**	☐ **Prosthetic Implant**
☐ **Diabetes/Kidney**	☐ **Swelling**	☐ **Infectious Diseases**	☐ **Any Transplant**
☐ **Herpes**	☐ **Seizures**	☐ **Venereal Diseases**	☐ **Joint Replacement**
☐ **Thyroid/Hormonal**	☐ **TMJ**	☐ **Psychiatric Care**	☐ **Arthritis**

MEDICATIONS

Name of Physician/Practice:	**Number:**
Pharmacy Name:	**Cross Streets:**

Please Check and Name the Medications You Are Taking:

☐ No Medications _____	☐ Hormone _____
☐ Antibiotics _____	☐ Thyroid _____
☐ Pain Medicine _____	☐ Birth Control Pills _____
☐ Heart Medicine _____	☐ Insulin _____
☐ Aspirin _____	☐ Ulcer/Nexium _____
☐ Cortisone/Steroids _____	☐ Bone Related _____
☐ Blood Thinner _____	☐ Antidepressants _____
☐ Blood Pressure _____	

If you are taking any additional medications please list them below

1.	**2.**	**3.**
4.	**5.**	**6.**
7.	**8.**	**9.**

1. Do you have any disease, condition, or problem not previously listed? ☐ Yes ☐ No
   If YES, please explain: _____
   _____
1. Are you currently under the care of a Physician for a current Problem? ☐ Yes ☐ No
   Nature of Treatment: _____
2. Have you had abnormal bleeding with previous extractions, surgery or trauma? ☐ Yes ☐ No
3. Have you ever been tested for HIV infection (AIDS)? ☐ Yes ☐ No
   Result of test: ☐ Positive ☐ Negative
4. 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
5. **Are you required to take antibiotics prior to ALL dental treatment?** ☐ Yes ☐ No

Financial Policy

Dr. Erik Foisy and the Team at Surprise Endodontics 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 any of our staff members as they 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 60 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. _____ (Pt. Initials)

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 60 days will be forward to a third party collection agency. You will be responsible for all collection fees and attorney fees in conjunction with collecting the balance due on your account._____ (Pt. Initials) _____(Date)

Patients without Dental Insurance:

For those patients without dental insurance we require **payment in full** at the time of service. We do offer financing options through Care Credit. Applications can be filled out online or over the phone. If you would like more information, 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**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this acknowledgement *

I, _____, may request a copy of Surprise Endodontics Notice of Privacy Practices.

I hereby permit Surprise Endodontics to use my health information, and/or to disclose my health information to my insurance company which is a third party payer, or to any party involved in my health care, which is the referring Dentist.

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 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)

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

ALL of the 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 Endodontics shall be borne by the undersigned.

Signed:_____ Date:_____

(Patient or Guardian)

Signed:_____ Date:_____

(Treating Dentist)