

**Northern Arizona Endodontics
PATIENT INFORMATION**

DATE _____

PATIENT (Ms., Mr., Mrs., Dr.) _____
(Last) (First) (M.I.) (Nickname)

MAILING ADDRESS _____
(Street) (City) (Zip)

HOME/CELL PHONE _____ EMAIL ADDRESS _____ SEX: M F

DATE OF BIRTH _____ Social Security Number _____

REFERRING DENTIST _____

EMPLOYER'S NAME _____ OCCUPATION _____

ALTERNATE CONTACT _____ RELATIONSHIP _____

HOME/CELL PHONE _____ WORK PHONE _____

BILLING INFORMATION (IF DIFFERENT FROM ABOVE)

NAME OF RESPONSIBLE PARTY _____
(Last) (First) (M.I.)

ADDRESS _____
(Street) (City) (Zip)

HOME PHONE _____ CELL PHONE _____ SEX: M F

S.S.# _____ EMPLOYER'S NAME _____

QUOTED FEES INCLUDE OFFICE VISITS, TREATMENTS, RECALL APPOINTMENTS, ANESTHETICS, X-RAYS, AND MEDICATIONS ADMINISTERED IN THE OFFICE. FEES MAY BE PAID IN THE FOLLOWING WAY (Please check one)
 TOTAL AMOUNT AT THE BEGINNING OF TREATMENT

VISA MASTERCARD DISCOVER CHECK CASH PRE-APPROVED FINANCING

DENTAL INSURANCE INFORMATION

1ST INSURANCE COMPANY NAME _____ PHONE# _____

ADDRESS _____
(Street) (City) (Zip)

NAME OF SUBSCRIBER _____ DATE OF BIRTH _____ SUBSCRIBER ID _____

2ND INSURANCE COMPANY NAME _____ PHONE# _____

ADDRESS _____
(Street) (City) (Zip)

NAME OF SUBSCRIBER _____ DATE OF BIRTH _____ SUBSCRIBER ID _____

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO NORTHERN AZ ENDODONTICS, AND I ALSO AUTHORIZE THE DOCTOR TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.

SIGNATURE _____ DATE _____
(Patient, or Parent/Guardian of Minor Patient)

PLEASE FILL OUT REVERSE SIDE ALSO

MEDICAL HISTORY

Please check any of the following which apply to you **now or in the past:**

	YES	NO		YES	NO
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease or Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

Any other diseases, problems, or disabilities? _____

Have you ever had a reaction to an anesthetic or drug such as Penicillin, Erythromycin, Novocaine, Codeine, Sulfa, Aspirin, etc or a reaction to Latex? _____

Medications taking at present _____

WOMEN: Are you pregnant? _____ If so what month? _____

ENDODONTIC TREATMENT LIMITATIONS

The purpose of endodontic treatment or root canal treatment is an attempt to save a tooth rather than removing it. Although treatment has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal treatment may require re-treatment, surgery, or even extraction. Treatment is usually non-surgical procedure, but in some cases a surgical approach is necessary. Before any treatment is begun, the reasons(s) will be fully explained, including alternative modes of therapy and any possible complications involved. Occasionally, pre-medication may be indicated. This will be discussed in advance.

THE FEE WILL NOT INCLUDE A PERMANENT FILLING OR CROWN ON THE TOOTH. YOU MUST RETURN TO YOUR GENERAL DENTIST TO HAVE THAT TREATMENT COMPLETED.

I ACCEPT ALL RESPONSIBILITY FOR PAYMENT OR DENTAL SERVICES RENDERED AND AGREE TO PAY THE ACCOUNT IN FULL. SHOULD THIS ACCOUNT BECOME DELINQUENT, I AGREE TO PAY ALL COSTS OF COLLECTION AND/OR REASONABLE ATTORNEY'S FEES.

SIGNATURE _____ **DATE** _____
(Patient, or Parent/Guardian of Minor Patient)

PLEASE, let us know how you're feeling today!



CONFIDENT



OPTIMISTIC



HAPPY



CURIOUS



UNDECIDED

DRAW YOUR OWN?



CAUTIOUS



FRIGHTENED



ANXIOUS



PAINED



MISERABLE