FOX RIVER
ENDODONTICS

Welcome To Our Practice

Thank you for trusting us with your dental care.
We promise to do our best to provide you with the finest care available.
If you have any questions, please do not hesitate to contact us.

Date _____

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Name _____ Birth Date _____

Sex ❑ M ❑ F Address _____ City _____ State _____ Zip _____

❑ Minor ❑ Married ❑ Widowed ❑ Single ❑ Separated ❑ Divorced

Home Phone _____ Cell Phone _____ E-mail _____

Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Dentist _____ Medical Doctor _____

Whom may we thank for referring you? *(e.g., General Dentist)* _____

Contact in case of emergency _____ Phone _____ Relation to Patient _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other *(If self, skip to next section)*

Name _____ S.S.# _____ Birth Date _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

Currently a patient in our office? ❑ Yes ❑ No E-mail _____ Cell Phone _____

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Insurance Company Name _____

Insurance Company Address _____ City _____ State _____ Zip _____

Insurance Company Phone _____

Group # _____ **ID #** _____

Insured Party _____ Relation to Patient _____

Sex: ❑ M ❑ F Birth Date _____ S.S # _____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell Phone _____ Email _____

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MEDICAL HISTORY

Have you been advised to pre-medicate for medical reasons *(e.g., antibiotics)* prior to dental treatment? ❑ Yes ❑ No

Explain: _____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N	
❑	❑	Rheumatic Fever	❑	❑	Blood Disorder	❑	❑	HIV
❑	❑	Mitral Valve Prolapse	❑	❑	Bruise Easily	❑	❑	Sexually Transmitted Diseases
❑	❑	Heart Murmur	❑	❑	Abnormal Bleeding	❑	❑	Low Blood Sugar
❑	❑	Blood Pressure - High or Low	❑	❑	A History of Drug Abuse	❑	❑	Kidney Trouble
❑	❑	Chest Pain / Angina	❑	❑	Eye Disease / Glaucoma	❑	❑	Osteoporosis / Osteopenia
❑	❑	Heart Attack(S)	❑	❑	Jaundice / Liver Disease	❑	❑	Osteonecrosis
❑	❑	Irregular Heart Beat	❑	❑	Hepatitis A B C (circle)	❑	❑	Contagious Diseases
❑	❑	Cardiac Pacemaker	❑	❑	Fainting Spells	❑	❑	Delay in Healing
❑	❑	Heart Surgery	❑	❑	Convulsions / Epilepsy	❑	❑	Tumor or Growth
❑	❑	Damaged Heart Valves	❑	❑	Stroke	❑	❑	Radiation / Chemotherapy
❑	❑	Mental Health Problems	❑	❑	Thyroid Trouble	❑	❑	Vertigo
❑	❑	Asthma	❑	❑	Diabetes	❑	❑	Issues Laying Back In a Dental Chair
❑	❑	Respiratory Problems	❑	❑	Memory Loss			
❑	❑	Tuberculosis	❑	❑	Are You Immunosuppressed? *(Possibly From Transplant Surgery)*			

Are you OR have you taken osteoporosis medications? ❑ Yes ❑ No If Yes, what _____

MEDICATION and ALLERGIES

List medication(s) you are taking: _____

_____

_____

_____

Are you allergic to or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Latex
❑	❑	Valium or other tranquilizers	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Amoxicillin

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

Please list any allergies other than drug allergies:

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

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)* **X** _____ **Reviewed by:** _____ **Date:** _____

FEES & PAYMENTS

Our professional services are rendered and charged to you in full at time of service. Therefore, payment for any service is due the day of treatment. We gladly accept Visa, Master Card, American Express, Discover or Care Credit, as well as, personal check or cash.

As a courtesy to patients with dental insurance, we are able to file to **SOME** insurance companies, but not all. We are considered out of network with all insurance companies. Your insurance policy is a contract between you and your insurance company. **Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated.** The patient or guarantor is ultimately responsible for all account balances regardless of insurance coverage.

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

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

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