OAKWOOD ★ ENDODONTICS

Patient Name: _____ **SSN:** _____ **Sex: M F**
Address: _____ City_____ State_____ Zip_____
Home #: _____ Cell #:_____ Age: _____ DOB: _____ ☐ Married ☐ Single
Employer: _____ Address: _____ Work #:_____
Driver's License #_____ Email: _____
Financial Responsible Person (if different from patient):_____Relationship:_____
Date of Birth: _____ DL#:_____SSN:_____ Phone #:_____
General Dentist: _____ Referred By (if different) _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Subscriber: _____ DOB: _____ SSN:_____
Primary Insurance Company:_____ Phone #:_____
Claims Mailing Address: PO Box_____ City: _____ State: _____Zip: _____
Employer: _____ Payor ID: _____
Subscriber ID#:_____ Group Number#: _____

I understand that I am responsible for all treatment received and also understand that if I have insurance, it will be filed as a courtesy to me. I also authorize my insurance company to issue payment directly to Oakwood Endodontics.

Signature of Patient/Guardian: _____ Date: _____

Health History

Reason for your visit? _____Estimation of your general health?_____
Preferred Pharmacy: _____ Pharmacy Phone #: _____
☐Yes ☐ No Are you Allergic to any medications? _____
Please list ALL medications you are taking at this time: _____
_____

Do you have or have you ever had any of the following:

____ Heart Disease	____ Glaucoma	____ Stomach Ulcers
____ Heart Attack	____ Diabetes	____ Kidney Problems
____ Heart Murmur	____ Anemia	____ Cancer
____ High Blood Pressure	____ Bleeding Problems	____ Radiation/Chemo
____ Rheumatic Fever	____ Systemic Lupus	____ Psychiatric Care
____ Mitral Valve Prolapse	____ Hepatitis	____ Fainting Tendency
____ Shortness of Breath	____ Thyroid Disease	____ HIV/AIDS
____ Chest Pains	____ Tuberculosis	____ Treatment w/Steroid
____ Sinus Problems	____ Severe Headaches	____ Organ Transplant
____ Lung Problem/Asthma	____ Seizures	____ Liver Problem/Jaundice
____ **Hip/Joint Replacement**	____ **Takes Pre-Med**	____ **Latex/Rubber Allergy**

Please list any other medical problems not listed above:

_____

☐Yes ☐ No Are you currently under a physician's care for any medical condition? _____
Physician's Name: _____ Phone #: _____
☐Yes ☐No Have you been hospitalized within the past year? If yes, what was the reason?

_____

☐Yes ☐ No **Women**: Are you pregnant? How many weeks? _____ Are you breast-feeding? _____
☐Yes ☐ No Are you taking birth control pills? Please note that antibiotics may decrease the effectiveness.
☐Yes ☐ No Are you taking bisphosphonates? (Osteoporosis Medication)
☐Yes ☐ No Are you anxious about being here today? ☐Yes ☐No Have you previously had root canal treatment?

Acknowledgement of Receipt of the *HIPPA Notice of Privacy Practice Policy* & *Oakwood Endodontics Financial Policy*

-I hereby acknowledge that I have read/requested a copy of the office *HIPPA Notice of Privacy Practice Policy*.
-I have been given the opportunity to ask questions regarding this policy and give Oakwood Endodontics the permission to send my information to my General Dentist/Specialist, Medical Physician and/or my Insurance Company if it is requested.
-I have read/accept *Oakwood Endodontics Financial Policy* and understand that I am responsible for any unpaid balance.

Signature of Patient/Guardian: _____ Date: _____