FAYETTE ENDODONTICS

Welcome! Thank you for selecting our specialty endodontic team! Please fill out this form completely. If you have any questions, please ask us – we will be happy to help you.

## PATIENT INFORMATION

NAME: _____ SALUTATION:_____

ADDRESS: _____ CITY: _____ZIP:_____

CELL PHONE #: _____ BIRTHDATE: _____

EMAIL: _____ GENERAL DENTIST: _____

PATIENT EMPLOYER: _____ PATIENT SS#: _____

EMERGENCY CONTACT (NAME & NUMBER) _____

## PRIMARY INSURANCE

NAME OF INSURED: _____

RELATIONSHIP TO PATIENT:_____

INSURANCE COMPANY: _____ EMPLOYER: _____

BIRTHDATE: _____ GROUP # : _____

ID #: _____ DRIVER'S LICENSE # OR SS#: _____

## SECONDARY INSURANCE (IF APPLICABLE)

NAME OF INSURED: _____

RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY: _____ EMPLOYER: _____

BIRTHDATE: _____ GROUP #: _____

ID#: _____ INSURANCE PHONE #: _____

# PATIENT MEDICAL HISTORY

Name_____ DOB: _____

Primary Care Physician: _____ Phone #: _____

Are you taking medication prescribed by a doctor or dentist? _____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years?

Explain: _____

Please list medications being taken: _____

Are you ALLERGIC to, or have you had any REACTIONS to, the following?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Local Anesthetics (e.g. novocain) | | | Sulfa Drugs | | |
| Penicillin | | | Codeine | | |
| Any Antibiotics (If yes, list below) | | | Latex Rubber | | |

Others ( please list) _____

Do you have or have you had, any of the following?

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | | | Heart Disease | | | Chest Pain | | |
| Heart Murmur | | | Heart Attack | | | Stroke | | |
| Cardiac Pacemaker | | | Rheumatic Fever | | | Angina | | |
| Fainting/ Seizures | | | Diabetes | | | Diverticulitis | | |
| Mitral Valve Prolapse | | | Tuberculosis | | | Arthritis | | |
| Low Blood Pressure | | | Leukemia | | | TMJ | | |
| Radiation Therapy | | | Liver Disease | | | Migraines | | |
| Epilepsy/ Convulsions | | | Kidney Disease | | | Cholesterol | | |
| Joint Replacement/ Implant | | | Crohn's Disease | | | Cancer | | |
| AIDS/ HIV infection | | | Asthma | | | Type: | | |
| Stomach Trouble | | | Abnormal Bleeding | | | Hepatitis | | |
| Ulcers | | | Thyroid | | | Type: | | |

Other: _____

Do you premedicate? (take antibiotics for any medical condition prior to dental appointments) _____

If yes, did you? _____ With what antibiotic? _____ For What? _____

Do you take blood thinners? _____ If yes, what kind _____

Females: Are you pregnant? _____ Are you nursing _____

I hereby authorize endodontic treatment to be performed on me in this facility. I have been given the opportunity to ask questions concerning treatment and have received adequate information to enable me to make an informed decision as to my care. I also understand that there are some risks associated with endodontic treatment.

Signature: _____ Date: _____

# PAYMENT POLICY

## John R. Haycock D.M.D.

## Thomas J. Lucas, D.M.D.

Payment is expected at each visit. We accept check, cash, credit cards and CareCredit. The person bringing the child for treatment is the responsible party for the bill (guarantor). We do not bill or attempt to collect from any third party with the exception of comprehensive dental insurance.

**INSURANCE**: We are happy to take assignment for your insurance with the following stipulations:

1. Deductibles must be met as well as any percentages not covered by your insurance.
2. Your insurance must take assignments and pay us directly.
3. Your estimated portion must be paid at time of service.
4. If payment is not received from your carrier within 30 days, regardless of reason, the balance is then your responsibility and must be paid within 30 days of notification.
5. If there is a credit balance after payment has been made by your insurance company, a refund will be sent to you within 30 days.
6. Correct insurance information must be given at the time of appointment or full payment will be expected.

We take insurance assignments only as courtesy to you. We will not get involved in any dispute with your carrier, but will be happy to provide any additional information to help you collect from your insurance company.

*We use checXchange for all returned checks with a charge of $35.00*
*A charge of 1.5% will be applied to any unpaid balance monthly.*
*Should your account be turned over to collection, you will be responsible for all cost of collection, without limitation, attorney's fee and court fees.*

I have read and understand this payment policy and agree to abide by its contents.

Signature: _____ Date: _____

FAYETTE ENDODONTICS

Dr. John Haycock & Dr. Thomas Lucas
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Fayetteville, GA 30214

www.fayetteendo.com

# HIPAA PRIVACY POLICY

HIPAA Privacy Practices Acknowledgement and Permission to Release Health Care Information.

I, _____ hereby authorize Fayette Endodontics to use and/or disclose protected healthcare information either medical or financial with the following people:

| Name | Relationship to patient |
|---|---|
| Name | Relationship to patient |

I give permission to leave messages on this phone # or email address:

_____

I authorize use of patient medical information may be discussed with patient's dentist, medical doctor and laboratory to best offer continuity of care.

I have been given the opportunity to read HIPAA regulations and understand the contents. I understand Fayette Endodontics will disclose this information only to provide quality care and payment for services.

| | |
|---|---|
| (Patient printed name) | (Date) |
| (Signature of Patient or Guardian) | ( Relationship to Patient) |