

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 DEN	TIST:		
PATIENT EMPLOYER:	PATIENT SS#:			
EMERGENCY CONTACT (NAME & NUM	1BER)			
	PRIMARY INSURANCE			
NAME OF INSURED:				
RELATIONSHIP TO PATIENT:				
INSURANCE COMPANY:	EMPLO	YER:		
BIRTHDATE:	GROUP # :			
ID #:	DRIVER'S LICENSE # OR S	SS#:		
SECOND	OARY INSURANCE (IF APPL	ICABLE)		
NAME OF INSURED:				
RELATIONSHIP TO PATIENT:				
INSURANCE COMPANY:	EMPLO	OYER:		
BIRTHDATE:	GROUP #:			
ID#·	INISTIRANCE DE	JONE #:		

PATIENT MEDICAL HISTORY

Name			DOB:							
Primary Care Physician:		Phone #:								
Are you taking medication p	rescrib	ed by a	a doctor o	or dentist? _						
Have you been hospitalized	for any	surgic	al operat	ion or serio	us illnes	s withir	the last	5 year	s?	
Explain:										
Please list medications being	g taken	:								
Are you <u>ALLERGIC</u> to, or hav	e you h	ad any	REACTIO	ONS to, the f	ollowin	g?				
			Yes	No				Yes		No
Local Anesthetics (e.g.	novoc	cain)			Sulf	a Drug	s			
Penicillin			Codeine							
Any Antibiotics (If yes,	list b	210111			Latex Rubber		201			
Ally Alltiblotics (If yes,	, IISt D	eiow)			Late	X Kubi	<i>J</i> C1			
Others (please list) Do you have or have you ha				?						
	Yes	No			Yes	No			Yes	No
High Blood Pressure			Heart Di	sease			Chest Pain			
Heart Murmur			Heart At	tack			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	antibiot	ics for	any med	ical conditio	n prior	to dent	al appoi	ntment	s)	
If yes, did you?	With w	/hat ar	ntibiotic?			For	What? _			
Do you take blood thinners?	·			If yes, what	kind					
Females: Are you pregnant?	·			Are you	nursing	s				
I hereby authorize endodon opportunity to ask question me to make an informed de with endodontic treatment.	s conce cision a	rning	treatmen	t and have r	eceivec	l adequa	ate infor	mation	to ena	ble
Signature:					1	Date:				

PAYMENT POLICY

John R. Haycock D.M.D. Thomas J. Lucas, D.M.D.

<u>Payment is expected at each visit.</u> 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.

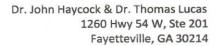
We take insurance assignments only as courtesy to you. We will not get involved in any dispute with your carrier, but will be happy to provide any additional information to help you collect from your insurance company.

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.				
at .	-			
Signature:	Date:			





www.fayetteendo.com

HIPAA PRIVACY POLICY

HIPAA Privacy Practices Acknowledgement and Permission to Release Health Care Information.					
I,Endodontics to use and/or disclose protecte with the following people:	hereby authorize Fayette ed healthcare information either medical or financial				
Name	Relationship to patient				
Name	Relationship to patient				
I give permission to leave messages on this	phone # or email address:				
doctor and laboratory to best offer continuing lands and laboratory to best offer continuing to read H	on may be discussed with patient's dentist, medical ty of care. IIPAA regulations and understand the contents. I e this information only to provide quality care and				
(Patient printed name)	(Date)				
(Signature of Patient or Guardian)	(Relationship to Patient)				