ENDODONTIC ASSOCIATES

Joel G. Jose, DDS
Judy Roh Jose, DDS, MDSc

Practice Limited to Endodontics

Date_____

PATIENT INFORMATION

❒ Mr. ❒ Mrs. ❒ Ms. ❒ Dr. First Name _____M.I._____ Last Name _____Nickname _____

Sex: ❒ Male ❒ Female Birth Date _____ Age _____Soc. Sec # _____

Street_____City _____ State_____Zip_____

Home Tel. (_____) _____ Cell (_____) _____ E-Mail _____

Dentist _____Referred By_____Have you ever been a patient of our practice? ❒ Yes ❒ No

Employer_____Work (_____) _____ Personal Payment Type: ❒ Cash ❒ Check ❒ Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT

❒ Self (If self, skip this section) ❒ Spouse ❒ Father ❒ Mother ❒ Other_____

Name_____S.S.# _____ Birth Date _____Age _____ Tel. (_____) _____

Street_____City _____ State_____Zip_____

Employer_____ _ _____Work (_____) _____

PRIMARY DENTAL INSURANCE COMPANY

Subscriber Name _____ Sex: ❒ M ❒ F

Birth Date _____Relation _____

Subscriber's SS# _____

Employer_____

Address _____

_____Tel. (_____) _____

Insurance Co. Name _____

Address _____

_____Tel. (_____) _____

Group # _____ Group Name _____

SECONDARY DENTAL INSURANCE COMPANY

Subscriber Name _____ Sex: ❒ M ❒ F

Birth Date _____Relation _____

Subscriber's SS# _____

Employer_____

Address _____

_____Tel. (_____) _____

Insurance Co. Name _____

Address _____

_____Tel. (_____) _____

Group # _____ Group Name _____

HIPAA PATIENT CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20 _____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

DENTAL HISTORY

Are you in pain?	❒ Yes ❒ No	Do you know which tooth is hurting you?	❒ Yes ❒ No
Is your tooth sensitive to hot and cold?	❒ Yes ❒ No	Does the pain wake you up at night?	❒ Yes ❒ No
Does hot or cold make the pain go away or ease up?	❒ Yes ❒ No	Are you under any unusual stress at home or work?	❒ Yes ❒ No
Does the tooth hurt when you bite down on it?	❒ Yes ❒ No	Do you grind your teeth?	❒ Yes ❒ No
Do you experience spontaneous pain not related to eating, hot or cold foods, or liquids?	❒ Yes ❒ No	Have you ever experienced TMJ problems?	❒ Yes ❒ No

The approximate date of your last dental visit_____ _____

MEDICAL HISTORY — *Will be kept confidential*

Do you have a personal physician? ❒ Yes ❒ No Physician's name _____

Date of last visit _____ Your current physical health is: ❒ Good ❒ Fair ❒ Poor

Do you have a medical condition that requires you to take antibiotics prior to dental appointments? ❒ Yes ❒ No

Do you or have you had any of the following diseases or problems?

(Please check Yes or No)			***(Medication taken for problem)***
Heart murmur or mitral valve prolapse	❒ Yes	❒ No	_____
Rheumatic fever or rheumatic heart disease	❒ Yes	❒ No	_____
High blood pressure	❒ Yes	❒ No	_____
Chest pain/Angina	❒ Yes	❒ No	_____
Heart attack/coronary artery disease	❒ Yes	❒ No	_____
Pacemaker	❒ Yes	❒ No	_____
Hemophilia/Abnormal bleeding	❒ Yes	❒ No	_____
Asthma/emphysema	❒ Yes	❒ No	_____
Shortness of breath	❒ Yes	❒ No	_____
HIV+/AIDS	❒ Yes	❒ No	_____
Tuberculosis	❒ Yes	❒ No	_____
Sinus problems	❒ Yes	❒ No	_____
Do you smoke or use tobacco in any form	❒ Yes	❒ No	_____
Stroke	❒ Yes	❒ No	_____
Kidney problem	❒ Yes	❒ No	_____
Seizure disorder (epilepsy/convulsions)	❒ Yes	❒ No	_____
Severe headaches	❒ Yes	❒ No	_____
Diabetes	❒ Yes	❒ No	_____
Hepatitis or other disease	❒ Yes	❒ No	_____
Cancer	❒ Yes	❒ No	_____
Ulcers or stomach problems	❒ Yes	❒ No	_____
Joint replacement	❒ Yes	❒ No	_____
Psychiatric treatment	❒ Yes	❒ No	_____
Drug/Alcohol abuse	❒ Yes	❒ No	_____

Other _____

Are you now taking or have you taken:

Anti-anxiety medications	❒ Yes	❒ No
Diet pills	❒ Yes	❒ No
Blood thinners (Coumadin, Aspirin, Advil)	❒ Yes	❒ No
Bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)	❒ Yes	❒ No
Pain killers (including aspirin)	❒ Yes	❒ No
Tranquilizers	❒ Yes	❒ No
Muscle relaxers	❒ Yes	❒ No
Insulin	❒ Yes	❒ No
Stimulants	❒ Yes	❒ No
Antidepressants	❒ Yes	❒ No

Are you allergic to any of the following:

Penicillin	❒ Yes	❒ No
Household bleach	❒ Yes	❒ No
Dental Anesthetics	❒ Yes	❒ No
Aspirin/Ibuprofen	❒ Yes	❒ No
Latex	❒ Yes	❒ No
Codeine	❒ Yes	❒ No
Iodine	❒ Yes	❒ No
Are you allergic to any drugs?	❒ Yes	❒ No

If yes, please list _____

_____

Below for women only *(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.)*

Is there a possibility of pregnancy?	❒ Yes	❒ No
Expected delivery date_____		
Are you nursing?	❒ Yes	❒ No
Are you taking birth control pills?	❒ Yes	❒ No

I certify that I have read and 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 Drs. Joel or Judy Jose or any other member of the staff responsible for any errors or omissions that I have made in the completion of this form.

X_____ **X**_____ **Date**_____

Signature of patient *(Parent or Guardian if Minor)* **Reviewed by**

Practice Name: **Endodontic Associates**

Address: **1375 Cherry Way, Suite 200**

City/State/Zip: **Gahanna, OH 43230**