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 (_____) _____

INSURANCE INFORMATION

Student …… ❒ Full Time ❒ Part Time ❒ N/A School Name and Address _____

Marital Status…… ❒ Married ❒ Divorced ❒ Widow ❒ Single ❒ Legally Separated

Employed…… ❒ Full Time ❒ Part Time ❒ Retired ❒ N/A

PRIMARY INSURANCE COMPANY

Subscriber Name _____ Sex: ❒ M ❒ F

Birth Date _____ Relation _____

Subscriber's SS# or ID#_____

Employer_____

Address_____

Tel. (_____) _____ Plan_____

Insurance Co. Name _____

Address_____

_____ Tel. (_____) _____

Group # _____ Group Name _____

SECONDARY INSURANCE COMPANY

Subscriber Name _____ Sex: ❒ M ❒ F

Birth Date _____ Relation _____

Subscriber's SS# or ID#_____

Employer_____

Address_____

Tel. (_____) _____ Plan_____

Insurance Co. Name _____

Address_____

_____ Tel. (_____) _____

Group # _____ Group Name _____

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_____

	NOT Anxious				VERY Anxious
Please rate your anxiety level regarding today's appointment: (circle one)	1	2	3	4	5

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	❒ Yes	❒ No
Latex	❒ Yes	❒ No
Codeine	❒ 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**

FEES & PAYMENTS

All fees are due upon completion of treatment. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental insurance we will be glad to submit your claim, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X_____ **Date**_____

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

The signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Endodontic Associates of the benefits otherwise payable to me.

X_____ **Date**_____

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

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 have regarding this Notice.

X_____ **Date**_____

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