PATIENTS HEALTH HISTORY & INFORMATION

You have been referred to our office by your dentist for root canal treatment. Upon completion, you will be sent back to you dentist for any additional / further care.

NAME:_____ **DATE OF BIRTH**: _____ **AGE:**_____
Last First Middle Initial

SEX:_____ **MARITIAL STATUS:**_____ **NAME OF SPOUSE:**_____**HOME PHONE:**_(_____)_____

HOME ADDRESS:_____
street city zip code

WORK PHONE_(_____)_____**OCCUPATION:**_____**SOCIAL SECURITY #:**_____

CELL PHONE_(_____)_____ **E-MAIL:**_____

EMPLOYED BY:_____ **DRIVERS LICENSE NUMBER:**_____
(REQUIRED IF PAYING BY CHECK) PLEASE SHOW I.D. TO RECEPTIONIST.

PATIENTS DENTIST: _____**REFERRED BY:**_____

PATIENTS MEDICAL DOCTOR AND ADDRESS:_____
Name Address

HAVE YOU HAD A SERIOUS ILLNESS OR MAJOR OPERATION?_____ **IF YES, WHAT &WHEN:**_____

_____

ARE YOU TAKING ANY MEDICATIONS NOW?_____ **IF YES, PLEASE LIST:**_____

_____

_____

HAVE YOU HAD ANY OF THE FOLLOWING ILLNESSES? IF YES, PLEASE CHECK THE APPROPRIATE BOX(S).

- ☐ Taking Fosamax/Didronel/Boniva/Aredia/Actonel/Reclast/Zometa "bone drug" -- Bisphosphonate drug

☐ TMJ (Jaw or Joint Problems)	☐ MIGRANE	☐ MULTIPLE SCEROSIS
☐ HEART DISEASE	☐ ANEMIA	☐ MITRAL VALVE PROLAPSE (HEART MURMUR)
☐ HEPATITIS	☐ STROKE	☐ FAINTING
☐ TUBERCULOSIS	☐ DIABETES	☐ EPILEPSY
☐ HIGH BLOOD PRESSURE	☐ ARTHRITIS	☐ RESPIRATORY DISORDER (I.E. ASTHMA)
☐ BLEEDING PROBLEMS	☐ KIDNEY DISORDER	☐ ARTIFICIAL JOINTS
☐ RHEUMATIC FEVER	☐ HERPES	☐ MONONUCLEOSIS
☐ THYROID PROBLEM	☐ VENEREAL DISEASE	☐ LIVER DISORDER
☐ GLAUCOMA	☐ HIV POSITIVE	☐ AIDS (ACQUIRED IMMUNE DEFICIENCY)
☐ BLOOD THINNERS	☐ BY PASS	☐ CANCER / CHEMOTHERAPY / RADIATION
☐ IRREGULAR HEARBEAT	☐ LUNG / EMPHESEMA	☐ ORGAN TRANSPLANT
☐ PACEMAKER	☐ SEIZURES	☐ TOBACCO USE: TYPE_____

OTHERS:_____

DO YOU TAKE AN ANTIBIOTIC BEFORE DENTAL APPOINTMENTS YES / NO WHY:_____

DID YOU TAKE AN ANTIBIOTIC FOR TODAYS APPOINTMENT YES / NO. WHAT DID YOU TAKE? _____

HAVE YOU EVER HAD AN ALLERGIC / SENSITIVE REACTION TO ANY OF THE FOLLOWING? IF SO, PLEASE CIRCLE:

DENTAL ANESTHETIC	PENICILLIN	CODEINE	ASPIRIN	SULFA
KEFLEX	MOTRIN	TETANUS	TYLENOL	OTHER:_____

ARE YOU UNDER STRESS_____ WOMAN: ARE YOU PREGNANT?_____IF YES, DUE DATE_____

PAYMENT IS REQUIRED UPON COMPLETION OF THE ENDODONTIC PROCEDURE. PAYMENT METHOD:

□ CASH □ CHECK □ VISA □ MASTERCARD □ DISCOVER □ CARE CREDIT

WHO IS LEGALLY RESPONSIBLE FOR PAYMENT?_____
Your insurance company is NOT legally responsible for payment. The patient, parent or guardian are.

IF A MINOR IS BEING TREATED, THE PARENT IS LEGALLY RESPONSIBLE FOR PAYMENT. PARENT IS REQUIRED TO STAY IN WAITING ROOM DURING TREATMENT. PLEASE DO NOT LEAVE THE OFFICE.

ANY BALANCE UNPAID BY YOUR INSURANCE COMPANY, WILL BE YOUR RESPONSIBILITY.

ROOT CANAL TREATMENT IS AN ATTEMPT TO RETAIN A TOOTH WHICH MAY OTHERWISE REQUIRE EXTRACTION. ALTHOUGH ROOT CANAL THERAPY HAS A HIGH DEGREE OF SUCCESS, IT CANNOT BE GUARANTEED. OCCASIONALLY A TOOTH WHICH HAS HAD ROOT CANAL THERAPY MAY REQUIRE RETREATMENT, SURGERY, OR EVEN EXTRACTION. THERE ARE TWO APPROACHES TO ROOT CANAL TREATMENT, NON SURGICAL AND SURGICAL. BOTH APPROACHES ARE NOT ALWAYS REQUIRED.

MICHAEL DEGROOD D.M.D., P.A. REQUIRES PAYMENT AT TIME SERVICE IS RENDERED. WE ACCEPT ALL MAJOR CREDIT CARDS AND DEBIT CARDS. (AMERICAN EXPRESS EXCLUDED). PAYMENT BY CHECK IS ACCEPTED, HOWEVER IN THE UNLIKELY EVENT YOUR CHECK IS RETURNED, WE RESERVE THE RIGHT TO RE-PRESENT THE ITEM ELECTRONICALLY, PLUS THE STATE ALLOWED PROCESSING FEE. I AUTHORIZE PAYMENT OF GROUP INSURANCE BENEFITS, OTHERWISE PAYABLE TO ME, DIRECTLY TO DR. MICHAEL DEGROOD D.M.D., P.A. MY SIGNATURE IS ALSO A FILE SIGNATURE FOR DENTAL INSURANCE. I UNDERSTAND ANY OUTSTANDING BALANCE MY INSURANCE DOES NOT PAY WILL BE MY RESPONSIBILITY. THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. WE ARE REQUIRED BY FEDERAL AND STATE LAW TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION. WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION FOR SUCH REASONS LISTED BELOW: ANOTHER HEALTH CARE PROVIDER TREATING YOU, TO OBTAIN PAYMENT FOR SERVICES RENDERED, IN CONNECTION WITH OUR HEALTH CARE OPERATIONS, IN REASONABLY SUSPECTED OF ABUSE OR NEGLECTED CASES, NATIONAL SECURITY AND FOR APPOINTMENT REMINDERS. YOU HAVE THE RIGHT TO ACCESS, AMEND, REQUEST A DISCLOSURE ACCOUNTING, AND REQUEST ALTERNATIVE COMMUNICATIONS REGARDING YOUR HEALTH INFORMATION. ALL MUST BE IN WRITING. YOU ARE ENTITLED TO RECEIVE THIS NOTICE IN WRITTEN FORM.

I AGREE THAT ANY DISPUTE ABOUT THE REASONABLENESS OR COMPUTATION OF FEES, OR ANY CLAIM OF NEGLIGENT OR INTENTIONAL ACTS OR OMISSIONS IN THE RENDERING OF PROFESSIONAL SERVICES BY ANY MEMBER OF MICHAEL DEGROOD D.M.D. P.A., STAFF, OR OUR DOCTORS, SHALL BE SUBMITTED TO BINDING ARBITRATION. IT IS UNDERSTOOD BY BOTH DOCTOR AND PATIENT THAT BY AGREEING TO SUBMIT ALL CLAIMS OR ASSERTIONS THAT EITHER PATIENT OR DOCTOR MAY HAVE AGAINST THE OTHER, ARISING OUT OF THIS AGREEMENT, ALL DISPUTES SHALL BE RESOLVED THROUGH ARBITRATION.

SIGNATURE:_____DATE:_____

REVIEWED BY:_____