OLD ORCHARD
ENDODONTICS

Mr. Mrs. Ms. Dr._____ Birth Date _____
(Last) (First)

E-mail_____ ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security Number_____ Phone (Home) _____ (Work) _____

Address_____ Phone (Cell) _____
(Street)

_____
(City) (State) (Zip Code)

Have you ever had any of the following? Please check all that apply:

☐ Artificial Joint	☐ Epilepsy	☐ High Blood Pressure	☐ Radiation Treatment
☐ Aids or HIV	☐ Excessive Bleeding	☐ Kidney Disease	☐ Rheumatic Treatment
☐ Blood Thinners	☐ Gastrointestinal Issues	☐ Liver Disease	☐ Sinus Problems
☐ Cancer	☐ Glaucoma	☐ Mental Disorders	☐ Stroke
☐ Chemotherapy	☐ Immunocompromised	☐ Mitral Valve	☐ Tuberculosis
☐ Diabetes	☐ Heart Disease	☐ Pacemaker	☐ Ulcers
☐ Drug Dependency	☐ Hepatitis	☐ Prolapse	

Are you pregnant? ☐ No ☐ Yes Due Date _____

Are you allergic to any of the following?

☐ Acetaminophen (Tylenol)	☐ Erythromycin	☐ Tetracycline
☐ Aspirin/Ibuprofen	☐ Latex	☐ Other_____
☐ Codeine	☐ Penicillin	
☐ Epinephrine	☐ Sulfa Drugs	

Have you ever had any complications following a dental treatment? ☐ No ☐ Yes (Explain)

_____

_____

Are you currently under the care of a physician? ☐ No ☐ Yes

Name of Physician _____ Physician Phone_____

Name of Pharmacy _____ Pharmacy Phone_____

Are you taking any medications? ☐ No ☐ Yes (Please list)_____

_____

_____

Have you ever been told to take an antibiotic prior to a dental visit? ☐ No ☐ Yes

PLEASE FILL OUT BACK SIDE OF THIS FORM

Who may we thank for referring you to our practice? _____

Your place of employment: _____

What is your occupation? _____

DENTAL INSURANCE INFORMATION

If you have dental insurance, please give your insurance card and/or forms to the receptionist. Please note, this procedure is not covered by Medicare or health insurance that is other than dental.

CONSENT FOR SERVICES

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

I understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will submit the patient's insurance forms and will credit any such collection to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I also understand that I am responsible for all fees rendered. In the event that Old Orchard Endodontics seeks enforcement of the agreement through the services of a collection agency, I shall be responsible for any incidental expenses, including all collection costs and reasonable attorney fees.

I have read the above conditions of treatment and agree to their content.

_____ Date: _____

Signature of patient, parent or guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (PRINT) _____ have received a copy of this office's Notice of Privacy Practices.

X _____ Date: _____ Relationship to Patient: _____