2024-2025 2024-2025 2024-2025

Endodontic & Periodontic Associates, Ltd. PATIENT ACCOUNT #_____

PATIENT DATA FOR TREATMENT - PLEASE COMPLETE FORM IN ITS ENTIRETY (*TWO SIDES*)

LEGAL NAME FIRST MIDDLE LAST

MR. MRS. MS. DR. _____

ADDRESS:_____ CITY/STATE/ZIP_____

HOME# ( ) CELL# ( ) D.O.B SS#

AGE:_____ MALE:___FEMALE:___ LANGUAGE:_____ EMAIL ADDRESS:_____

EMPLOYER NAME: PHONE# ( ) OCCUPATION

EMPLOYER ADDRESS: CITY: STATE/ZIP:

PREFERRED PHARMACY/LOCATION/PHONE #

MARITAL STATUS (Circle One): SINGLE MARRIED DIVORCED WIDOWED

SPOUSE NAME:_____ DOB:_____ SS#: _____

REFERRED TO US BY: REASON FOR VISIT:

DATE OF LAST PHYSICAL EXAM:_____/_____/_____

In the following questions, circle "Y" for yes or "N" for no. Your answers are for our records only and will be kept confidential.

DO YOU USE ANY OF THE FOLLOWING? Cigarettes Y or N Snuff Y or N Chewing Tobacco Y or N

HAVE YOU EVER HAD:	HAVE YOU EVER TAKEN ANY OF THESE MEDICATIONS:
Y or N MITRAL VALVE PROLAPSE	Y or N FEN PHEN OR REDUX
Y or N HEART MURMUR	Y or N AREDIA/ZOMETA/FOSAMAX/ACTONEL/BONIVA
Y or N RHEUMATIC FEVER (HISTORY OF)	Y or N XYGEVA/PROLIA/RECLAST
Y or N ABNORMAL HEART CONDITIONS (HEART SURGERY, HEART ATTACK, HEART INFECTION (ENDOCARDITIS), STENT, CONGENITAL DEFECTS, ANGINA, ETC.)	HAVE YOU EVER HAD ANY INFECTIOUS DISEASES:
	Y or N HEPATITIS/TUBERCULOSIS
Y or N CONGESTIVE HEART DISEASE	Y or N VENEREAL DISEASES/GONORRHEA/ SYPHILIS/HERPES
Y or N ARTIFICIAL HEART VALVE or DEFECTIVE HEART VALVE	Y or N AIDS/HIV POSITIVE/ARC
Y or N PACEMAKER	
Y or N PROSTHETIC DEVICES _____	ARE YOU:
Y or N JOINT REPLACEMENTS (KNEE, HIP, ETC.)	Y or N ALLERGIC TO A LOCAL ANESTHETIC?
Y or N ABNORMAL BLEEDING (PAST/PRESENT)	Y or N ALLERGIC TO LATEX?
Y or N HIGH BLOOD PRESSURE	Y or N ALLERGIC TO ANY MEDICATIONS/FOOD?
Y or N ANEMIA	IF YES, WHAT?_____
Y or N LIVER/KIDNEY PROBLEM/CIRRHOSIS, ETC.	Y or N TAKING ANY BLOOD THINNERS
Y or N SICKLE CELL ANEMIA/TRAIT	IF YES, WHAT?_____
Y or N DIABETES/ENDOCRINE DISORDERS. WHAT IS YOUR A1C? _____	Y or N CONSUME ALCOHOL AND/OR TAKE RECREATIONALDRUGS
Y or N GLAUCOMA/RETINAL SURGERY	IF YES, HOW MUCH _____
	IF YES, HOW OFTEN _____
Y or N ASTHMA/EMPHYSEMA/RESPIRATORY PROBLEMS	Y or N ANY OTHER PAST OR CURRENT MEDICAL CONDITIONS?
Y or N SINUS/NASAL PROBLEMS	IF YES, WHAT?_____
Y or N CHEMO THERAPY TREATMENT FOR CANCER	FEMALES ONLY:
Y or N TREATMENT FOR OSTEOPOROSIS	Y or N PREGNANT? If Yes, for how long?_____
Y or N RADIATION THERAPY	Y or N TAKING BIRTH CONTROL PILLS? *

PHYSICIAN'S NAME: _____ PHONE # ( ) _____

List all prescription, herbal, over the counter medications, or birth control pills you are currently taking:

_____

_____

*Antibiotics are often prescribed in the course of dental treatment. They can interfere with the absorption of birth control pills, thus making them ineffective. While taking antibiotics, alternative methods of contraception are recommended.

PATIENT/FINANCIAL RESPONSIBLE PARTY SIGNATURE:_____ DATE _____

PATIENT'S SIGNATURE (If different from Financially Responsible Party and over 18 years old:

_____ DATE _____

Reviewed by:_____ Date:_____

Endodontic & Periodontic Associates, Ltd. PATIENT ACCOUNT #_____

PATIENT DATA FOR TREATMENT - PLEASE COMPLETE FORM IN ITS ENTIRETY (*TWO SIDES*)

PRIMARY DENTAL INSURANCE

PRIMARY DENTAL INSURANCE PLAN NAME_____PHONE # ( ) _____

ADDRESS _____ CITY/STATE/ZIP _____

POLICY/ID # _____GROUP#_____EFFECTIVE DATE_____

SUBSCRIBER INFORMATION: RELATIONSHIP TO PATIENT_____ (IF SELF, SKIP TO NEXT SECTION)

NAME _____ SS # _____D.O.B _____

ADDRESS_____ CITY/STATE/ZIP _____

HOME#_____ CELL#( )_____ WORK PHONE # ( )_____

EMPLOYER NAME/ADDRESS _____ OCCUPATION_____

UNION NAME & PHONE # (If Applicable)_____

SECONDARY DENTAL INSURANCE

SECONDARY DENTAL INSURANCE PLAN NAME_____PHONE # ( ) _____

ADDRESS _____ CITY/STATE/ZIP _____

POLICY/ID # _____GROUP#_____EFFECTIVE DATE_____

SUBSCRIBER INFORMATION: RELATIONSHIP TO PATIENT_____ (IF SELF, SKIP TO NEXT SECTION)

NAME _____ SS # _____D.O.B _____

ADDRESS_____ CITY/STATE/ZIP _____

HOME#_____ CELL#( )_____ WORK PHONE # ( )_____

EMPLOYER NAME/ADDRESS _____ OCCUPATION_____

UNION NAME & PHONE # (If Applicable)_____

RESPONSIBLE PARTY INFORMATION
IF PATIENT IS A MINOR, THIS SECTION MUST BE COMPLETED

NAME OF RESPONSIBLE PARTY_____ RELATIONSHIP TO PATIENT_____

ADDRESS _____ CITY/STATE/ZIP _____D.O.B_____

SS# _____HOME # ( ) _____ CELL # ( )_____

EMPLOYER NAME & ADDRESS_____ CITY/STATE/ZIP _____

EMPLOYER PHONE _____ OCCUPATION_____

EMERGENCY CONTACT INFORMATION

NAME OF EMERGENCY CONTACT _____ RELATIONSHIP _____

HOME PHONE# ( )_____WORK PHONE# ( ) _____EXT_____

ADDRESS _____ CITY/STATE/ZIP _____PHONE ( ) _____

CLOSEST RELATIVE NOT LIVING WITH YOU _____ RELATIONSHIP_____

ADDRESS _____ CITY/STATE/ZIP _____PHONE ( ) _____

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT OF OURS? YES_____ NO_____

IF YES, WHO?_____ RELATIONSHIP_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and CONSENT FORM

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, payment activities, and healthcare operations.

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.

PATIENT/ RELATIVE PHI DISCLOSURE CONSENT

I am giving my consent to E & P to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member(s):

1)_____

Name **Relationship to Patient** **Phone Number**

2)_____

Name **Relationship to Patient** **Phone Number**

Right to Revoke: 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.

Patient Name: _____

Signature: _____ **Date:** _____

(Legal Guardian, if Patient is a minor)

Relationship to Patient: _____

To be completed by E & P staff if not signed

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign _____ Communication barriers prohibited obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement _____ Other (Please specify

Employee Signature: _____ **Date:** _____

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENFITS DISCLOSURE

ENDODONTIC & PERIODONTIC ASSOCIATES, LTD.

Patient Name _____

Responsible Party's Name _____
(If other than Patient)

Patient ID Number _____

I. Payment Responsibility for Services provided at Endodontic & Periodontic Associates, LTD.

a. I, as responsible party, take full responsibility in consideration for the services and supplies provided to the patient by the dentist and/or hygienist at Endodontic & Periodontic Associates.

b. All dental services furnished are charged directly to the patient or responsible party. My insurance coverage is a contract between me and my insurance company to help me meet dental expenses. It is not for Endodontic & Periodontic Associates to provide services on the basis that my insurance company will always pay all charges, as coverage varies greatly.

c. Endodontic & Periodontic Associates' fees are not based on usual and customary allowances of insurance companies. We are a specialty practice whose fee schedule is competitive with other specialists in our area.

d. I am responsible for providing Endodontic & Periodontic Associates with a valid Driver's License, State Identification Card, and or passport at the time services are rendered. (Valid photo identification is required.)

e. If a private employer or government insurance program covers my treatment, I authorize the dentists to bill any such insurer for all services provided. My insurance coverage may provide that some portion of the bill will remain my personal responsibility, such as my deductible, co-payment, or charges not covered by my dental or medical insurance. I also understand and acknowledge the following:

   i. A statement for the services rendered will be sent to me on a monthly basis.

   ii. The Dentist or Hygienist involved in my care may not be a participating provider in my insurance plan or network, and I may have greater financial responsibility for their services if they are not under contract with my dental plan.

   iii. It is my responsibility to provide all insurance coverage information to my dental provider, as well as to verify eligibility of coverage for services being rendered. Any questions regarding my dental and or medical insurance coverage or benefit level should be directed to my insurance plan and will be based on my certificate of coverage.

   iv. If I do not consent, or later revoke my consent, to the release of my information to any insurer that I have identified, I will be responsible to pay all charges for the treatment and services received.

Initial _____ v. If I refuse to provide my social security number, Endodontic & Periodontic Associates will require full payment at the time of service.

   vi. A Finance charge of 1.5% per month (18% APR) will be applied to balances over 60 days, unless written arrangements are made.

   vii. Endodontic & Periodontic Associates reserves the right to charge a failed appointment fee up to $200.00 for appointments not cancelled without 48 hours advanced notice.

   viii. All checks returned will be assessed a $30.00 returned check fee.

   ix. All financial agreement and payment plan arrangements are on a limited basis. If the contract goes into default, Endodontic & Periodontic Associates has the right to transfer unpaid balances to a collection agency for recovery.

   x. If necessary, Endodontic & Periodontic Associates may institute legal proceedings on any unpaid balances. I fully understand that I will be responsible for paying attorney fees, finance charges, court costs and post judgment interest.

II. Assignment of Benefits:

a. I hereby assign to Endodontic & Periodontic Associates, Ltd. all of my rights and claims for reimbursement under any medical or dental insurance policy for which benefits may be available to pay Endodontic & Periodontic Associates, Ltd. for the services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

b. I have read and fully agree to each of the statements in this form and sign below as my free and voluntary act.

Financially Responsible Party's Signature

_____ **Date:** _____

Patient's Signature (If different from Financially Responsible Party and over 18 years old.)

_____ **Date:** _____

White – Office Copy

Pink – Patient Copy