2024-2025 2024-2025 2024-2025

E & P ENDODONTIC & PERIODONTIC ASSOCIATES, LTD.

HEALTH HISTORY

Patient Name _____ Date _____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last physical exam_____
4. Are you now under a physician's care for a particular problem? Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe Y N
   _____
   _____
6. Height:_____Weight:_____
7. **DO YOU HAVE OR HAVE YOU HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? Y N
   - B. Congenital Heart Disease? Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease. Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder? Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? Y N
   - G. Liver disease (Jaundice, Hepatitis)? Y N
   - H. Kidney Disease? Y N
   - I. Diabetes? Y N
     What is your A1C ? _____
   - J. Thyroid Disease (Goiter)? Y N
   - K. Arthritis? Y N
   - L. Stomach Ulcers or Colitis? Y N
   - M. Glaucoma/Retinal Surgery? Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? Y N
   - O. Radiation (X-ray) treatment for Cancer? Y N
   - P. Clicking or popping of jaw joint, pain near ear difficulty opening mouth, grind or clench teeth? Y N
   - Q. Sinus or Nasal problems? Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system?
   - S. HIV, AIDS or ARC? Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? Y N
   - B. Anticoagulants (Blood thinners)? Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? Y N
   - E. Steroids (Cortisone, etc.)? Y N
   - F. Tranquilizers? Y N
   - G. Insulin or Oral Anti-Diabetic Drugs? Y N
   - H. Digitalis Inderal, Nitroglycerin or other Heart Drug? Y N
   - I. Any regular prescription medicine, pill or drugs? Y N
     If YES, please list _____
     _____
   - J. Herbal or Holistic remedies, Vitamins or over the counter medications? Y N
     If YES, please list _____
     _____
   - K. Have you ever taken Xygeva/Prolia/Reclast? Y N
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? Y N
   - B. Penicillin or other antibiotic? Y N
   - C. Sedatives, Barbiturates? Y N
   - D. Aspirin or Ibuprofen? Y N
   - E. Codeine or other painkillers? Y N
   - F. Latex or Rubber Products? Y N
   - G. Other allergies or reactions? Please list:_____ Y N
     _____
10. Do you smoke or chew tobacco? Y N
    How much per day?_____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y N
12. Do you consume alcohol and/or take recreational drugs? Y N
    If so, how much _____ How often_____
13. Have you had any serious problems associated with any previous dental treatment? Y N
14. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N
15. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N
16. Do you wish to talk to the doctor privately about anything? Y N
17. **FEMALES ONLY**
    - A. Are you Pregnant? Y N
      If so, how long?_____
    - B. Are you nursing? Y N
    - C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date _____ Signature of Person Completing Health History _____ Doctor's Initials _____

FORM F-2A

Reviewed by:_____ Date:_____

PATIENT INFORMATION

PATIENT NAME

ADDRESS

CITY ST ZIP

HOME PHONE WORK PHONE

CELL PHONE

BIRTHDATE AGE M / F

SINGLE MARRIED DIVORCED/WIDOWED

SOCIAL SECURITY #

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT
*** IF PATIENT IS A MINOR, THIS SECTION MUST BE COMPLETED***

SOCIAL SECURITY # DOB

NAME

RELATIONSHIP TO PATIENT

ADDRESS

CITY ST ZIP

PHONE

OCCUPATION

EMPLOYER

BUSINESS ADDRESS

CITY ST

BUSINESS PHONE

YOUR SPOUSE'S NAME

SPOUSE EMPLOYER

BUSINESS ADDRESS

BUSINESS PHONE EXT.

IS ANOTHER MEMBER OF YOUR FAMILY OR
RELATIVE A PATIENT OF OURS?

NAME

RELATIONSHIP TO PATIENT

PERSON TO CONTACT FOR EMERGENCIES

NAME

RELATIONSHIP TO PATIENT

PHONE NUMBER

ADDRESS

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY ST ZIP

REFERRED TO US BY

NAME

ADDRESS

PHONE

REASON FOR VISIT

PREFERRED PHARMACY

DENTAL INSURANCE

PRIMARY CARRIER

EMPLOYER

INSURANCE COMPANY

ADDRESS

PHONE

INSURED NAME

DATE OF BIRTH

RELATIONSHIP TO PATIENT

UNION NAME AND #

GROUP #

INSURED SS#

SECONDARY CARRIER

EMPLOYER

INSURANCE COMPANY

ADDRESS

PHONE

INSURED NAME

DATE OF BIRTH

RELATIONSHIP TO PATIENT

UNION NAME AND #

GROUP #

INSURED SS#

BEST E-MAIL ADDRESS(ES)

ENDODONTIC &
PERIODONTIC ASSOCIATES, LTD.

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

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

Initial _____

    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