MARTIN ENDODONTICS

Patient Information

Name:_____ Date of Birth: _____Sex: M F

Mailing Address:_____ City:_____ Zip:_____

Soc. Sec. # _____ Cell #:_____Home #:_____

Email Address: _____

Employer:_____ City: _____ Bus. Phone: _____

Regular Dentist:_____ Referring Dentist: _____

Physician: _____Your general health (circle one): Good Fair Poor

In case of emergency, whom should we contact? _____Relationship:_____

Emergency Contact Phone #: _____

Dental Insurance

Primary Insurance Company: _____Are you the subscriber? YES NO

Subscriber's Name (If not the patient): _____Subscriber's birthday: _____

ID#: _____ Group #: _____

NOTE: We will file a claim for you but it is your responsibility to pay any co-insurance, deductible amount or balance not paid for by your insurance company, at the time of service.

Medical History

Please check any of the following conditions that you currently have or have had in the past:

_____Heart Condition	_____Hemophilia	_____Hepatitis/Liver Disease	_____Cancer/Tumor
_____Heart Attack/Stroke	_____Lung Disease	_____Thyroid Disease	_____Radiation Therapy
_____Heart Murmur	_____Tuberculosis	_____Glaucoma	_____Chemotherapy
_____Artificial Heart Valve	_____Asthma	_____Cortisone Medicine	_____AIDS, ARC, HIV+
_____Heart Pacemaker	_____Kidney Trouble	_____Phen-Fen/Redux	_____Epilepsy/Seizures
_____Rheumatic Fever	_____Diabetes	_____Drug/Alcohol Addiction	_____Anxiety/Depression
_____Artificial Joint	_____Sickle Cell	_____High Blood Pressure	_____Osteoporosis

List any diseases, conditions or problems not noted above: _____

List any medication you are currently taking: _____

_____

ALLERGIES:Please check any of the following allergies you have or have had in the past:

_____Penicillin or other antibiotics _____Codeine or other narcotics

_____Latex (Rubber) _____ Other: _____

Have you ever had a complication during or after dental treatment: YES NO If yes, what? _____

For Women: Are you pregnant or do you think you may be pregnant? YES NO Due Date: _____

Are you on birthcontrol? YES NO

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I authorize my insurance company to issue payment directly to the Martin Endodontics. I authorize the use of this signature for all insurance claims. I understand I am responsible for all fees not covered by my insurance. I will not hold Martin Endodontics, D.D.S. responsible for any complications that result from any errors or omissions that I may have made.

Signature of patient/guardian:_____ Date: _____

I hereby acknowledge that I have received/read a copy of this office's HIPAA Notice of Privacy Policy, or can ask for a copy. I have been given the opportunity to ask any questions regarding this Notice.