Salisbury Endodontics

PATIENT INFORMATION

Patient Name _____ Male / Female

Nickname _____Social Security # _____ Birth Date _____

Mailing Address _____

City _____ State _____ Zip _____

Cell Phone # _____ Ok to leave message? ____ Y ____ N Ok to Text ____Y ___N

Home Phone # _____ Ok to leave message? ____ Y ____N

Email _____

Employer's Name _____ Occupation _____

Preferred Pharmacy _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____

Phone # _____ Relation to you _____

DENTAL HISTORY

General Dentist or person referring (if applicable) _____

Have you ever had an injury to (*select all that apply*): _____ Teeth _____ Mouth _____Chin Have you ever had a doctor recommend **PreMed** antibiotics prior to dental treatment due to joint replacement (ex: knee, hip shoulder), or cardiac history (ex. heart valve replacement)? ___ Y ___ N

Are you currently taking any blood thinners? If yes, Please List _____

MEDICAL HISTORY

Are you currently being treated by a physician? Y____ N____ Reason _____

Physician _____ Last Visit _____ Phone _____

Do you have any drug allergies? Y____ N____

If yes, please list:

Are you currently taking any prescriptions or over-the-counter medications? ____ Y ____ N

Please list, with dosage: _____
_____
_____

Have you ever responded adversely to medical or dental treatment? ___ Y ____ N If yes, describe:

Check if you have or have ever had any of the following:

☐	Anemia	☐	Epilepsy	☐	PTSD
☐	Anxiety	☐	Headaches	☐	Radiation Treatment
☐	Arthritis, Rheumatism	☐	Heart Problems	☐	Respiratory Disease
☐	**Artificial Heart Valve**	☐	Hemophilia	☐	Rheumatic Fever
☐	**Artificial Joint**	☐	Hepatitis Type:_____	☐	Sexually Transmitted Infection
☐	Back Problems	☐	Hight Blood Pressure	☐	Sinus Problems
☐	Blood Disease	☐	HIV/AIDS	☐	Stroke
☐	Cancer/Chemo	☐	**LATEX ALLERGY**	☐	Swollen Neck Glands
☐	Chemical Dependency	☐	Liver Disease/Jaundice	☐	Thyroid Problems
☐	Circulatory Problems	☐	Low Blood Pressure	☐	Ulcer
☐	Diabetes	☐	Nervous Problems		

Women: Are you pregnant? ____Y ____ N Nursing? ____ Y ____N Birth control? ____ Y ____ N

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform the office of any changes in my medical status.

Signature_____ Date_____

Salisbury Endodontics

Office Payment Policy

Patients with dental insurance: **You** are responsible for your bill: **not** your insurance company. As a courtesy to you, we will assist in filing your claim. However, this is not a guarantee of payment by your insurance company. Due to so many different insurance policy regulations, we ask that you pay your estimated out of pocket fees when services are rendered. We do not file medical insurance. Upon hearing from the insurance company, we will either: (1) refund any overpayment or (2) bill you for the balance. Full payment is due from you upon receipt of your statement. **A finance charge of 18% will be charged after 30 days**. Please be aware that some insurance companies will pay no benefits or a lower percentage of benefits if your dentist is **not** a participating provider. Some companies have other restrictions applying to the non-participating provider, for example, Blue Cross Blue Shield of NC reimburses the patient only. Please be aware if your insurance requires you to see a participating provider.

We are only In Network with: Aetna

Patients with no dental insurance: Payment is expected, in full, on the day of service.

All consultation/x-ray fees in this office must be paid in full the day of service. Credit balances requiring a refund will be mailed to you.

Consultation (x-ray / vitality testing) fees range from: $150.00 to $280.00

Root canal treatments range from: $1200.00 to $1550.00

Root canal retreatments range from: $1380.00 to $1780.00

There will be a $32.00 fee for all returned checks.
In the event your account is turned over to collections, a collection fee of $15.00 will be accessed.

Note: Root canal therapy does not guarantee restoration of the tooth. Rarely, after root canal treatment, the tooth may still fracture or become infected, requiring additional treatment. **Retreatment of a crowned, infected tooth will be performed at no cost to the patient, WITHIN SIX MONTHS, from the date of original treatment. After six months, the patient will be responsible for the retreatment fee, if you have not had the permanent restoration placed by your general dentist. No refunds will be given for fractured teeth left unprotected by a crown or final restoration.**

Signature of patient or legal guardian _____ Date_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I. _____, have reviewed a copy of this office's Notice of Privacy Practices. (A copy is available in the lobby.).

_____

Please Print Name

_____

Signature

_____

Date

Person(s) OK to release appointment or medically related information concerning you.

_____ Relation(s) _____

_____ Relation(s) _____

_____ Relation(s) _____

For office use only

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

- o Individual refused to sign.
- o Communications carriers prohibited obtaining acknowledgment.
- o An emergency situation prevented us from obtaining acknowledgment
- o Other (Please Specify) _____