



Date _____

PATIENT INFORMATION

Mr. Mrs. Ms Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____
Sex: Male Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____
 Military Unit _____ Rank _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Home Tel.(_____) _____ Cell. (_____) _____ Have you ever been a patient of our practice? Yes No
Referred By _____ Has a family member ever been a patient of our practice? Yes No
Dentist _____ Medical Doctor _____
Employer _____ Bus. Tel. (_____) _____
In case of emergency, please contact _____ Tel. (_____) _____ Relation _____
Who do we have permission to discuss billing and treatment with? _____ (Please print clearly) Phone number _____

WHO WILL BE RESPONSIBLE FOR YOUR PAYMENT

Self (If self, skip this section) Spouse Father Mother Other _____
Name _____ S.S. # _____ Birth Date _____ Age _____ Tel. (_____) _____
Street _____ Apt. _____ City _____ State _____ Zip _____
 Military Unit _____

PRIMARY DENTAL INSURANCE COMPANY


Employer _____
Bus. Address _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____
Group # _____ Group Name _____
Insured Party _____ Relation _____
Sex: M F Birth Date _____ S.S. # _____
Street _____ City _____
State, Zip _____ Tel. (_____) _____

SECONDARY DENTAL INSURANCE COMPANY


Employer _____
Bus. Address _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____
Group # _____ Group Name _____
Insured Party _____ Relation _____
Sex: M F Birth Date _____ S.S. # _____
Street _____ City _____
State, Zip _____ Tel. (_____) _____

MEDICAL INSURANCE

*All patients with trauma, retreatment, and surgery
Employer _____ Bus. Address _____
Bus. Tel. (_____) _____ Plan _____ Ins. Co. Name _____ I.D. # _____
Address _____
Group # _____ Group Name _____ Insured Party _____ Relation _____
Sex: M F Birth Date _____ S.S. # _____ Street _____ City _____
State, Zip _____ Tel. (_____) _____

 **HINESVILLE OFFICE**
111 East Mills Avenue,
Hinesville, GA 31313
Tel: 912-463-4405
Fax: 912-463-4939

 **RICHMOND HILL OFFICE**
10220 Ford Ave,
Richmond Hill, GA 31324
Tel: 912-756-5960
Fax: 912-756-5964

 **ST. SIMONS ISLAND**
1804 Frederica Road, Ste. B
St. Simons Island, GA 31522
Tel: 912-268-2800
Fax: 912-434-9936



Date: _____

Full Name: _____

DENTAL CONCERN

Reason for today's visit

Are you in pain? Yes No If yes, For How Long? _____

Please circle your level of pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

ALLERGIES

Are you allergic to, or had a reaction to:

- Y N Penicillin Y N Sulfa drugs Y N Local anesthetic (numbing med) Y N Amoxicillin
 Sodium pentothal / Valium / other tranq. Aspirin Codeine or other narcotics Latex
 Soy Eggs / Yolk Sulfites I have no known allergies.

Please list any other medication or antibiotic you are allergic to:

MEDICATION

Are you now taking, or have you ever taken:

- Y N Nerve pills Y N Pain killers (including aspirin) Y N Muscle relaxers Y N Stimulants
 Diet pills Tranquilizers Insulin Antidepressants
 Blood thinners Coumadin No. of dose _____ how often _____ Date of Last INR _____ Value _____
 Aspirin therapy Plavix Heparin
 Nitroglycerin Digitalis

Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel) Date: _____

Please list any other medication(s) you are taking including natural, herbal, or homeopathic products.

[MEDICATION | DOSAGE | FREQUENCY]

MEDICAL HISTORY

Are you under care of a physician? Yes No Date Last Visit _____

Provider Name _____ Contact Number _____ Condition _____ Recent Hospitalization Dates _____ Reason _____

Is your blood pressure usually Low Normal High Today's BP _____

Alcohol usage: I don't drink rarely drink 1-2 drinks per week 1-2 drinks daily

Tobacco usage: I don't use I quit using tobacco I smoke cigarettes cigar pipe marijuana I use dip or snuff

How often is the product(s) used: _____ How many years _____



Date: _____

Full Name: _____

MEDICAL HISTORY

Do you have, or have you had, any of the following diseases, medical conditions, or procedure?

Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Lung Disease
<input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding	Type: _____ Year(s): _____	<input type="checkbox"/> <input type="checkbox"/> Stent Placement	<input type="checkbox"/> <input type="checkbox"/> Snore
<input type="checkbox"/> <input type="checkbox"/> Blood transfusion	<input type="checkbox"/> <input type="checkbox"/> Radiation Treatment	Type: _____ Date: _____	<input type="checkbox"/> <input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Atherectomy Date: _____	<input type="checkbox"/> <input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> <input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> <input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> <input type="checkbox"/> CABG Date: _____	<input type="checkbox"/> <input type="checkbox"/> Pulmonary Fibrosis
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Treated for Venereal Disease	<input type="checkbox"/> <input type="checkbox"/> Implanted Defibrillator	<input type="checkbox"/> <input type="checkbox"/> Asthma
<input type="checkbox"/> <input type="checkbox"/> Fainting Spells	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Murmurs	<input type="checkbox"/> <input type="checkbox"/> (AICID Inhaler)
<input type="checkbox"/> <input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> <input type="checkbox"/> Knee Replacement Year ____	<input type="checkbox"/> <input type="checkbox"/> Angina	<input type="checkbox"/> <input type="checkbox"/> Weekly <input type="checkbox"/> Daily
<input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizure	<input type="checkbox"/> <input type="checkbox"/> Hip Replacement Year ____	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Seasonal <input type="checkbox"/> Monthly
Date of last seizure: _____	<input type="checkbox"/> <input type="checkbox"/> Any Joint Replacement Year ____	<input type="checkbox"/> <input type="checkbox"/> Heart Attack Date: _____	<input type="checkbox"/> <input type="checkbox"/> Hospitalized
<input type="checkbox"/> <input type="checkbox"/> Immune System Problems	<input type="checkbox"/> <input type="checkbox"/> Hepatic Encephalopathy	<input type="checkbox"/> <input type="checkbox"/> Pace Maker Date: _____	Date: _____
<input type="checkbox"/> <input type="checkbox"/> Lupus	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A, B, C	<input type="checkbox"/> <input type="checkbox"/> Stroke Date: _____	<input type="checkbox"/> <input type="checkbox"/> Valley Fever
<input type="checkbox"/> <input type="checkbox"/> Inflammatory Rheumatism	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Dysrhythmias	<input type="checkbox"/> <input type="checkbox"/> Emphysema
Last BUN: _____ Date: _____	<input type="checkbox"/> <input type="checkbox"/> Coronary Insufficiency	<input type="checkbox"/> <input type="checkbox"/> Chest Discomfort	<input type="checkbox"/> <input type="checkbox"/> Sinus Condition
<input type="checkbox"/> <input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> <input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> <input type="checkbox"/> Valve Replacements	<input type="checkbox"/> <input type="checkbox"/> Chronic Bronchitis
<input type="checkbox"/> <input type="checkbox"/> Glaucoma	Last episode: _____	Last Ejection Fracture % ____ Date: ____	<input type="checkbox"/> <input type="checkbox"/> COPD
<input type="checkbox"/> <input type="checkbox"/> Problems with healing	<input type="checkbox"/> <input type="checkbox"/> Liver Surgery Date: _____	<input type="checkbox"/> <input type="checkbox"/> Irregular Pulse	
<input type="checkbox"/> <input type="checkbox"/> Diabetes		<input type="checkbox"/> <input type="checkbox"/> Atrial Fibrillation	
Last Blood Sugar _____		<input type="checkbox"/> <input type="checkbox"/> Angioplasty Date: _____	

Last HgA1C _____

Any Other Conditions: _____

For women only: (Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Is there a possibility of pregnancy? Expected delivery date: _____	<input type="checkbox"/> <input type="checkbox"/> Are you nursing?
<input type="checkbox"/> <input type="checkbox"/> Are you taking birth control pills: If yes: _____	

ACKNOWLEDGMENT

I certify that I have read and understand the medical questions above and have answered them truthfully. I will not hold the doctors or staff of Coastal Endodontics responsible for errors or omissions that I have made while completing this form.

X _____ Signature of Patient or Guardian X _____ Date X _____ Reviewed by X _____ Date

I also acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have had regarding this Notice.

X _____ Signature of Patient or Guardian X _____ Date X _____ Reviewed by X _____ Date

This signature on my file is my authorization for the release of information necessary to process my claim or pursue payment for my treatment. I hereby authorize payment to the doctors of Coastal Endodontics from the benefits otherwise payable to me. I further understand that any estimate for my portion is only an estimate. It is my responsibility to follow up with my insurance company for unpaid balances. I understand any unpaid balances will start to accrue 18% interest after 30 days. I understand Coastal Endodontics will pursue every means to collect their fees to include collection agencies and small claims court.

X _____ Signature of Patient or Guardian X _____ Date X _____ Reviewed by X _____ Date

For visits within 12 months, I certify I have had no changes to my health history.

X _____ Signature of Patient or Guardian X _____ Date X _____ Reviewed by X _____ Date