Coastal Endodontics
comfortable root canals

Date _____ www.coastalendo.net

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name _____ (FIRST NAME) M.I. ___ Last Name _____ (LAST NAME) Nickname _____

Sex: ☐ Male ☐ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Home Address _____ Apt. _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell. (_____) _____ Have you ever been a patient of our practice? ___Yes ___No

Military Unit: _____ Rank: _____

Referred By _____ _____ Has a family member ever been a patient of our practice? ☐ Yes ☐ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Medical Doctor _____ (FIRST NAME) _____ (LAST NAME)

Employer _____ Bus. Tel. (_____) _____

In case of emergency, please contact _____ (FIRST NAME) _____ (LAST NAME) 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 _____ (FIRST NAME) _____ (LAST NAME) S.S. # _____ Birth Date _____ Age _____ Tel. (_____) _____

Street _____ Apt. _____ City _____ State _____ Zip _____

☐ Military Unit

PRIMARY DENTAL INSURANCE COMPANY

Employer _____ (FIRST NAME) (LAST NAME)

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel. (_____) _____

Group # _____ Group Name _____

Insured Party _____ _____ Relation _____

Sex: ☐ M ☐ F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel. (_____) _____

SECONDARY DENTAL INSURANCE COMPANY

Employer _____ (FIRST NAME) (LAST NAME)

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel. (_____) _____

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 _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel. (_____) _____ Plan _____ Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP) Tel. (_____) _____

Group # _____ Group Name _____ Insured Party _____ _____ Relation _____

Sex: ☐ M ☐ F Birth Date _____ S.S. # _____ Street _____ City _____

State, Zip _____ Tel. (_____) _____

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

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

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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 — Worst Pain

1 2 3 4 5 6 7 8 9 10

ALLERGIES

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Penicillin	☐	☐	Sulfa drugs	☐	☐	Local anesthetic (numbing med)	☐	☐	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 currently taking any of the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Nerve pills	☐	☐	Pain killers (including aspirin)	☐	☐	Muscle relaxers	☐	☐	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 _____

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Date: _____ **Full Name:** _____

MEDICAL HISTORY

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

Y N
- ☐ ☐ Anemia
- ☐ ☐ Abnormal bleeding
- ☐ ☐ Blood transfusion
- ☐ ☐ Hemophilia
- ☐ ☐ HIV/AIDS
- ☐ ☐ Tuberculosis
- ☐ ☐ Fainting Spells
- ☐ ☐ Thyroid Condition
- ☐ ☐ Epilepsy/Seizure

Date of last seizure: _____
- ☐ ☐ Immune System Problems
- ☐ ☐ Lupus
- ☐ ☐ Inflammatory Rheumatism

Last BUN: _____ Date: _____
- ☐ ☐ Fibromyalgia
- ☐ ☐ Glaucoma
- ☐ ☐ Problems with healing
- ☐ ☐ Diabetes

Last Blood Sugar _____

Last HgA1C _____

Y N
- ☐ ☐ Cancer

Type: _____ Year(s): _____
- ☐ ☐ Radiation Treatment
- ☐ ☐ Chemotherapy
- ☐ ☐ Stomach Ulcers
- ☐ ☐ Treated for Venereal Disease
- ☐ ☐ Liver Disease
- ☐ ☐ Knee Replacement Year ____
- ☐ ☐ Hip Replacement Year ____
- ☐ ☐ Any Joint Replacement Year ____
- ☐ ☐ Hepatic Encephalophaty
- ☐ ☐ Hepatitis A, B, C
- ☐ ☐ Kidney Disease
- ☐ ☐ Coronary Insufficiency
- ☐ ☐ Ulcerative Colitis

Last episode: _____
- ☐ ☐ Liver Surgery Date: _____

Y N
- ☐ ☐ Heart Disease
- ☐ ☐ Stent Placement

Type: _____ Date: _____
- ☐ ☐ Atherectomy Date: _____
- ☐ ☐ CABG Date: _____
- ☐ ☐ Implanted Defibrillator
- ☐ ☐ Murmurs
- ☐ ☐ Angina
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Heart Attack Date: _____
- ☐ ☐ Pace Maker Date: _____
- ☐ ☐ Stroke Date: _____
- ☐ ☐ Dysrhythmias
- ☐ ☐ Chest Discomfort
- ☐ ☐ Valve Replacements

Last Ejection Fracture %____ Date: ____
- ☐ ☐ Irregular Pulse
- ☐ ☐ Atrial Fibrillation
- ☐ ☐ Angioplasty Date: _____

Y N
- ☐ ☐ Lung Disease
- ☐ ☐ Snore
- ☐ ☐ Sleep Apnea
- ☐ ☐ Cystic Fibrosis
- ☐ ☐ Pulmonary Fibrosis
- ☐ ☐ Asthma
- ☐ ☐ (AICID Inhaler)
  - ☐ Weekly ☐ Daily
  - ☐ Seasonal ☐ Monthly
- ☐ ☐ Hospitalized

Date: _____
- ☐ ☐ Valley Fever
- ☐ ☐ Emphysema
- ☐ ☐ Sinus Condition
- ☐ ☐ Chronic Bronchitis
- ☐ ☐ COPD

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
- ☐ ☐ Is there a possibility of pregnancy? Expected delivery date: _____
- ☐ ☐ Are you taking birth control pills: If yes: _____

Y N
- ☐ ☐ Are you nursing?

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.

Signature of Patient or Guardian 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.

Signature of Patient or Guardian 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.

Signature of Patient or Guardian X_____ Date_____

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

Signature of Patient or Guardian X_____ Date _____