Microsurgical Endodontics

Registration

Patient name:_____Preferred Name:_____
Address:_____Apt#:_____City: _____State: ___ Zip:_____
Phone# Home: (___) ___-_____ Work: (___) ___-_____Cell: (___) ___-_____
Preferred phone contact: (please circle) Home Work Cell
Social Security #:___-___-____ Date of birth: ___-___-____
Referring dentist:_____

Complete only if information is not provided above

Person responsible for acct:_____Relationship to Patient: _____
Address:_____ City: _____State: ___ Zip: _____
Phone# Home: (___) ___-_____ Work: (___) ___-_____Cell: (___) ___-_____

Insurance Information

Name of Insured:_____ Relationship to Patient:_____
Name of Insurance Company:_____ Ins Co. Phone: (___) ___-_____
Address:_____ City: _____State: ___ Zip: _____
Member ID#:_____ Group ID#:_____

If coverage is through someone other than you, please provide the following:

Their Name:_____ Their Employer or Retirement Plan: _____
Their Date of Birth___/___/____ Social Security #___-___-____ Work Phone (___) ___-_____

We never want you to be surprised about the cost of treatment. If you have questions about cost, please ask. You are responsible for payment at the time of treatment. Your insurance is a contract between you, your employer and your insurance company, and Microsurgical Endodontics is not a party to that contract. Therefore, your insurance coverage of our fee is the best **estimate** we are able to determine based on the information provided by you and your insurance carrier. Please understand that our calculations are strictly **ESTIMATES** and **there is no guarantee that your insurance company will reimburse us according to the estimate that they provide.** You are responsible for any portion of the fee that your insurance carrier does not pay, regardless of reason.

I hereby acknowledge that I have read and understand the above statement, authorize payment of the dental benefits otherwise payable to me directly to Microsurgical Endodontics, and authorize release of any information relating to a claim. I also acknowledge that a copy of the Privacy Policy for Microsurgical Endodontics has been made available to me.

_____ _____
Signature of Patient or Parent/Guardian Date

MEDICAL/DENTAL HISTORY

Name of your Physician:_____ **Date of Last Visit**:_____

Please circle any of the following that you have or have had:

Heart Trouble	Cancer	Sinus Trouble
Angina	Radiation Treatment	Environmental Allergies
Rheumatic Fever	Arthritis	Asthma
Mitral Valve Prolapse	Osteoporosis	Hives or Skin Rash
Heart Murmur	Joint Replacement Surgery	Substance Abuse
Stroke	Liver Disease-Jaundice/Hepatitis	Depression/Anxiety
High Blood Pressure	Kidney Disease	Herpes Oral (cold sores)
Bleeding Disorder	Thyroid Condition	Venereal Diseases
Fainting Spells/Seizures	Reflux/GERD	HIV Positive
Clenching/Grinding of Teeth	Ulcers	AIDS
TMJ Disorder	Crohn's/Colitis	Tuberculosis
Wear a Dental Night Guard	Diabetes	Major Surgery

Please name all current medications, dosage, & reason for taking them:

Name	Dose	Reason	Name	Dose	Reason

Please list any medications you are allergic or have reacted adversely to:

Name	Reaction	Name	Reaction

Do you smoke?_____
Women: Are you pregnant?_____ **If Yes due date:**_____
Do you have any other disease, condition, or problem not listed above?_____ **Please explain**_____

1. Have you had any trouble associated with previous dental treatment (dizziness, fainting or reaction to dental anesthetic)? Yes No Reaction _____
2. Are you Allergic to Latex? Yes No Reaction _____
3. Does a doctor require you to take antibiotics prior to dental treatment? Yes No Reason _____

To the best of my knowledge, the above information is correct and complete.

Patient's Signature	**Date**	**Dentist**	**Date**
Patient's Signature (Updating Paperwork)	**Date**	**Dentist**	**Date**

Revised November 10, 2022