Patient Registration

(Please Print) **Lehigh Valley Endodontics-Bethlehem, PC**

Married
Single
Widowed
Divorced

Today's Date:_____

_____

Last Name First Name Middle Initial

Address_____Date of Birth _____

Street City State Zip

Social Security # _____ If patient is a minor, responsible parent _____ Home Phone _____
Business Phone _____ Employed by _____Occupation _____
General Dentist _____Referred by _____
Physician _____Phone _____Date of Last Physical _____
In case of emergency contact _____ Relationship _____Phone _____

Health History

Have you had or do you currently have…	Yes	No	Notes	Have you had or do you currently have…	Yes	No	Notes
Heart murmur				Kidney disease			
Mitral valve prolapse				Tuberculosis			
Rheumatic fever				Asthma			
High blood pressure				Anemia			
Chest pain, angina				Hepatitis/liver disease			
Heart attack				Arthritis			
Stroke				Ulcers			
Cardiac pacemaker				HIV/AIDS			
Heart surgery				Seizures			
Thyroid trouble				Glaucoma			
Diabetes				Sinusitis			
Cancer				TMJ pain or "clicking"			

Are you under the care of a physician? Yes No For what condition? _____
In the last five years, have you ever been: (If yes, please circle and explain)
Hospitalized: Yes No _____
Had a serious illness? Yes No _____
Do you have a prosthetic joint? Yes No If so, describe where: _____
Do you have a heart valve replacement of vascular graft? Yes No Where? _____
Must you take an antibiotic before dental treatment? Yes No If so, what and how many? _____

Medications:_____

_____

Are you allergic to or had a reaction to:

Local anesthetics (adrenalin) Yes ___ No ___ Codeine or other narcotics Yes ___ No ___
Penicillin Yes ___ No ___ Other medications Yes ___ No ___
Other antibiotics Yes ___ No ___ Other non-drug allergies Yes ___ No ___
Aspirin or Ibuprofen Yes ___ No ___ **LATEX** Yes ___ No ___
Women: Are you pregnant? Yes ___ No ___ If so, estimated delivery date: _____ Are you nursing? _____
Chief Dental Complaint_____

Patient Registration

Name of Insurance Company _____ Phone _____
Insurance address _____ City _____ State _____Zip _____
Subscriber's Name _____ SS#_____
Birth Date _____ Patients Relationship to Subscriber _____
Subscriber's Address _____
Subscriber's Employer _____ Group or Policy # _____

Is patient covered by additional dental insurance? Yes ____ No ____
If "Yes" please complete information:
Name of secondary insurance company _____ Phone _____
Insurance address _____
Subscriber's Name _____ SS# _____
Birth Date _____ Patient's relationship to Subscriber _____
Subscriber's Employer _____ Group or Policy # _____

** I understand that my dental insurance is a contract between the insurance carrier and myself, and not a contract between my insurance carrier and the Doctor. I understand that I am still FULLY responsible for all dental fees. I understand these fees are due and payable at the time services are rendered unless a prior financial arrangement has been made. I assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account or refunded to me in excess of the amount due.

_____

Patient / (or Guardian) Signature Date

All Patients

I, the undersigned, certify that the information on these pages is correct and accurate. I also certify that I am the patient (or authorized agent of the patient) authorized to furnish all information requested. I understand that all requested fees are due and payable at the time of service and I am fully responsible for these fees. I understand any fees denied by my insurance plan is also my responsibility.
I agree that if my account is referred to an outside agency or attorney for collection, I will be responsible for an additional Collection Fee of fifty dollars ($50.00). Also, if there are repeated rescheduling requests on my part, I will be responsible for a Cancellation Fee of fifty dollars ($50.00) billable to the patient. I/We have read this disclosure and agree.

Patient / (or Guardian) Signature _____ Date _____

There are certain conditions where a tooth cannot be saved. Sometimes it can be diagnosed during the consultation and then recommended not to proceed. Sometimes these conditions are not visible during the examination or visible by x-rays, or discovered when the tooth is treated. Some examples include microfractures, perforations, resorption, iatrogenic difficulties (previous treatment by another dentist that did not turn out favorably) and unusual anatomical configurations of the tooth. In today's modern endodontics, we now have surgical operating microscopes to detect certain unfavorable dental conditions during the procedure and thus stop treatment at that time.
In the event that your tooth is found to be unsalvageable during the course of root canal treatment or retreatment, and it ultimately needs to be extracted, we will not use the code for root canal treatment or retreatment of a root canal. Instead, we will use the code for incomplete endodontic treatment. Some insurance plans do not cover this fee, therefore, you will be responsible for this fee at the time of your visit. We will submit this code on your behalf to your insurance plan and in the event your plan does cover this code you will be sent a refund.

I will be responsible for payment for incomplete endodontic treatment at the time of service.

Patient / (or Guardian) Signature _____ Date _____