

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

E-Mail \_\_\_\_\_

Patient \_\_\_\_\_  
First Name Middle Initial Last Name Nick Name

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

*(The reason we ask for your social security number is so we may verify and file your dental insurance, IF AN ALTERNATE ID # IS NOT AVAILABLE. Without it we are unable to provide this service. If you do not wish to provide us with your social security number then you will have to pay your fee in full at the time of service and file your own dental insurance.)*

Who may we thank for referring you? \_\_\_\_\_

Employer \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

**Pharmacy Name & Location** \_\_\_\_\_

Have you ever had any of the following? **(CHECK BOXES THAT APPLY)**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Heart Murmur                   | <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Sinus trouble                        |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Tuberculosis                 | <input type="checkbox"/> Asthma                               |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> Thyroid Problems             | <input type="checkbox"/> Fainting spells                      |
| <input type="checkbox"/> Seizures                       | <input type="checkbox"/> STDS/AIDS/HIV                | <input type="checkbox"/> High blood pressure                  |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Pacemaker                    | <input type="checkbox"/> Low blood pressure                   |
| <input type="checkbox"/> General Allergies              | <input type="checkbox"/> Hepatitis                    | <input type="checkbox"/> <b>Artificial knee, hip or joint</b> |
| <input type="checkbox"/> <b>Artificial Heart Valves</b> | <input type="checkbox"/> <b>Mitral valve Prolapse</b> | <input type="checkbox"/> Epilepsy                             |
| <input type="checkbox"/> Swollen neck glands            | <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> Anxiety or panic attacks             |
| <input type="checkbox"/> Osteoporosis                   | <input type="checkbox"/> Immune Problems              | <input type="checkbox"/> Kidney trouble                       |
| <input type="checkbox"/> Ulcers                         | <input type="checkbox"/> Cardiovascular disease       | <input type="checkbox"/> Respiratory problems                 |
| <input type="checkbox"/> Psychiatric Care               | <input type="checkbox"/> Chemical Dependency          | <input type="checkbox"/> Anemia                               |
| <input type="checkbox"/> Other _____                    |   |   |

**~Are you currently on any illegal drugs?**  yes  no

The following question is for patients with certain heart conditions, joint replacements, plastic surgery or other known reasons that an antibiotic is needed before dental treatment and that you have been advised by your treating physician that you should be pre-medicated. Are you pre-medicated?  yes  no

**(Women)**

Are you pregnant?  yes  no    Are you nursing?  yes  no    Are you taking birth control pills?  yes  no

Are you allergic or have you had a reaction to?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Penicillin or Amoxicillin | <input type="checkbox"/> NSAIDS/Ibuprofen/Motrin |
| <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Codeine                   | <input type="checkbox"/> Latex                   |
| <input type="checkbox"/> Iodine            | <input type="checkbox"/> Sulfa                     | <input type="checkbox"/> Other _____             |

If you are taking any medicine including non-prescription medicine, please list.

\_\_\_\_\_  
\_\_\_\_\_

Signature of Patient or Responsible Party

Date

**INFORMED CONSENT**

I acknowledge that payment is due at the time of service. I understand that I am financially responsible for all fees including any collection costs, attorney cost and any court costs associated with the payment of fee for service. There will be a \$30.00 charge for any returned checks.

*Any account NOT paid in full within 30 days of invoice date will be assessed a monthly late fee of \$10.00.*

The fee that is quoted is for the doctor’s time and service, apart from the outcome.

I give permission to Clark Endodontics LLC to email unencrypted x-rays and/or correspondence to my dentist and/or myself.

I will be charged \$10.00 for any additional copies of a 3D Cone beam Scan.

I have read and agree to the above consent.

\_\_\_\_\_  
**Signature of Patient or Responsible Party**

\_\_\_\_\_  
**Date**

**ACKNOWLEDGEMENT OF PRIVACY RIGHTS**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected Health Information. I understand that my information may be used or disclosed for treatment, payment or health care operations-which means for providing healthcare to me, the patient; handling billing and payment; and taking care of other health care operations.

I have been informed of my dental provider’s *Notice of Privacy Practices* containing a more complete description of the uses and disclosures pf my protected health information. I understand that I have the right to read the ‘*Notice*’ before signing this agreement. If I ask, my provider will provide me with the most current *Notice of Privacy Practices*.

I have the right to revoke this consent in writing at any time, except to the extent that my provider has taken action relying on the consent.

\_\_\_\_\_  
**Signature of Patient or Responsible Party**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Date**