BEACH ENDODONTICS

PLEASE PRINT
PATIENT'S NAME (Dr. / Mr. / Mrs. / Ms.) _____
HOME ADDRESS (NO P.O. BOX #'S)
_____CITY/STATE/ZIP_____

HOME PHONE _____CELL PHONE_____WORK PHONE_____

E-MAIL ADDRESS _____BEST NUMBER TO CONTACT YOU_____
SOCIAL SECURITY NUMBER_____DATE OF BIRTH_____

EMPLOYER_____

WORK ADDRESS_____CITY/STATE/ZIP_____

SPOUSE/ RESPONSIBLE PARTY (IF PATIENT IS A MINOR, LIST GUARDIAN)_____

HOME ADDRESS (NO P.O. BOX #'S)
_____CITY/STATE/ZIP_____

HOME PHONE _____CELL PHONE_____WORK PHONE_____
SOCIAL SECURITY NUMBER_____DATE OF BIRTH_____

EMPLOYER_____

WORK ADDRESS_____ CITY/STATE/ZIP_____

NEAREST RELATIVE NOT LIVING WITH YOU_____
HOME ADDRESS (NO P.O. BOX #'S)
_____CITY/STATE/ZIP_____
HOME PHONE _____CELL PHONE_____WORK PHONE_____

NAME OF YOUR DENTIST_____

NAME OF YOUR PHYSICIAN _____

PREFERRED PHARMACY NAME AND PHONE NUMBER _____

WHOM ARE WE TO THANK FOR RECOMMENDING YOU TO OUR OFFICE?
_____

DO YOU HAVE ***DENTAL*** INSURANCE? **YES/NO** IS THIS INSURANCE THROUGH YOUR EMPLOYER? **YES/NO**
NAME OF ***PRIMARY DENTAL*** INSURANCE? _____
NAME OF ***PRIMARY*** INSURED HOLDER_____
RELATIONSHIP TO INSURED HOLDER_____INSURANCE #_____

DO YOU HAVE A SECONDARY ***DENTAL*** INSURANCE? **YES/NO** IS THIS INS.THROUGH AN EMPLOYER? **YES/NO**
NAME OF ***SECONDARY Dental*** Ins. INSURANCE_____
NAME OF ***SECONDARY*** HOLDER_____
RELATIONSHIP TO INSURED HOLDER_____ INSURANCE #_____

THE ABOVE INFORMATION, TO THE BEST OF MY KNOWLEDGE, IS CURRENT AND CORRECT.

PATIENT OR RESPONSIBLE PARTY SIGNATURE_____/DATE_____

Health History

PLEASE CIRCLE **"YES"** OR **"NO"** TO **EACH** QUESTION:

1.	HAVE YOU BEEN A PATIENT IN THE HOSPITAL IN THE LAST 2 YEARS? IF YES, WHY?	YES	NO
2.	HAVE YOU BEEN UNDER A DOCTOR'S CARE DURING THE LAST 2 YEARS? IF YES, WHY?	YES	NO
3.	PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING ANY DRUGS YOUR DENTIST HAS PRESCRIBED FOR YOUR CURRENT PROBLEM: **PLEASE NAME**.		
4.	DO YOU REQUIRE PREMEDICATION PRIOR TO DENTAL PROCEDURES? IF YES, WHY?	YES	NO
5.	ARE YOU ALLERGIC TO PENICILLIN, CODEINE, LATEX OR ANY OTHER MEDICATIONS? IF YES, WHAT?	YES	NO
6.	HAVE YOU EVER HAD ANY EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT? IF YES, WHEN?	YES	NO
7.	HAVE YOU HAD ANY OTHER SERIOUS ILLNESSES? IF YES, WHAT?	YES	NO
8.	HAVE YOU EVER TAKEN BISPHOSPHONATE MEDICATION? (EX. FOSAMAX, BONIVA, RECLAST, ZOMETA, ACTONEL)	YES	NO
.	WOMEN: ARE YOU PREGNANT OR NURSING?	YES	NO

CHECK ANY OF THE FOLLOWING WHICH YOU MAY HAVE HAD:

_____HEART TROUBLE	_____JAUNDICE	_____ARTHRITIS	_____ASTHMA
_____CONGENITAL HEART LESIONS	_____EPILEPSY	_____HEART MURMUR	_____DIABETES
_____RHEUMATIC FEVER	_____HIV ANTIBODY	_____COUGH	_____HEPATITIS
_____HIGH BLOOD PRESSURE	_____TUBERCULOSIS	_____SINUS TROUBLE	_____ANEMIA
_____PSYCHIATRIC	_____STROKE	_____ULCER	_____COLITIS

THE ABOVE INFORMATION, TO THE BEST OF MY KNOWLEDGE, IS CURRENT AND CORRECT.

PATIENT OR RESPONSIBLE PARTY SIGNATURE_____/DATE_____

GREGORY T. ENGEL, DMD, MS

FINANCIAL POLICY

PLEASE READ THOROUGHLY AND INITIAL THE HIGHLIGHTED AREAS!

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage. However, **WE CANNOT GUARANTEE ANY ESTIMATED COVERAGE.** Because the insurance policy is an agreement between you and the insurance company, YOU are directly responsible for all charges. Please know that we will do everything possible to see that you receive the maximum benefits from your policy. Insurance is filed the day after your visit with the information you provide in this paperwork.

If for some reason your insurance company has not paid their portion within 30 days from the filing of the insurance, you are responsible for payment at that time. **IT IS YOUR RESPONSIBILITY TO FOLLOW-UP WITH THE INSURANCE COMPANY REGARDING NONPAYMENT ON YOUR CLAIM.**

PAYMENTS DUE UPON TREATMENT

_____ For no insurance, payment is expected **in full** at time of treatment. We can make financing arrangements with you.

_____ **For participating insurances** (those insurances in which this office has agreed to accept that company's payment rates)– **Aetna Extend, Delta Dental**,(**NOT Delta Care**), **Humana (NOT Medicare / Medicaid)** the **applicable out of pocket is to be paid at the time of treatment**. **This amount is only an estimate; you are still responsible for any remaining balance after insurance pays.**

_____ For nonparticipating insurances (all other insurances), a payment of **one-third (1/3) of your total fee is to be paid at the time of treatment.** We will file these insurances as a courtesy to you. You are responsible for the doctor's total fee regardless of what insurance pays.

_____ **CBCT scan, post space, canal obstructions, I&D, incomplete root canals, and resin restoration may not be covered by your insurance benefits. You, as the insured, are responsible for any remaining balance after insurance is filed.**

OTHER FEES

_____ **NO SHOWS** –As a courtesy our office will remind you of your treatment appointment in advance. If you do not show at your scheduled time without 24 hour prior notification to our office, you will be assessed an $85 no show fee. Your insurance will not cover this fee.

PARTIAL TREATMENT – If you begin endodontic therapy and then chose on your own recognizance not to complete treatment, you are responsible for the appropriate half-treatment fee, and all subsequent possible oral health complications.

In order to complete treatment and give insurance companies a reasonable amount of time to make payment, there will be no finance charge for the first 60 days after the start of treatment. Any account with a balance after 60 days will be subject to a finance charge of 1.5% per month (18% APR) as well as any expenses that may be incurred collecting past due accounts including 33 1/3% attorney fees, court costs and interest. Any checks returned to us will be charged a $35 returned check fee.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE. I HEREBY AUTHORIZE THE ABOVE NAMED ENDODONTISTS TO FILE DENTAL INSURANCE ON MY BEHALF AND AUTHORIZE PAYMENT DIRECTLY TO HIM FOR THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. **I AM AWARE THAT I AM RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURANCE COMPANY.**

_____ / _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

_____ _____

Signature **Date**

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because

_____.

Persons to Whom Information May Be Disclosed:

NAME, RELATIONSHIP, PHONE NUMBER:

_____ _____ **(___)_____-_____ Financial/ Health/ Both**

_____ _____ **(___)_____-_____ Financial/ Health/ Both**

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation i.e. power of attorney forms)