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 ANSWER EACH QUESTION:

1. HAVE YOU BEEN A PATIENT IN THE HOSPITAL IN THE LAST 2 YEARS? YES NO
IF YES, WHY?

2. HAVE YOU BEEN UNDER A DOCTOR'S CARE DURING THE LAST 2 YEARS? YES NO
IF YES, WHY?

3. PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING ANY DRUGS YOUR DENTIST HAS PRESCRIBED FOR YOUR CURRENT PROBLEM: **PLEASE NAME**. YES NO

4. DO YOU REQUIRE PREMEDICATION PRIOR TO DENTAL PROCEDURES? YES NO
IF YES, WHY?

5. ARE YOU ALLERGIC TO PENICILLIN, CODEINE, LATEX OR ANY OTHER MEDICATIONS? YES NO
IF YES, WHAT?

6. HAVE YOU EVER HAD ANY EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT? YES NO
IF YES, WHEN?

7. HAVE YOU HAD ANY OTHER SERIOUS ILLNESSES? YES NO
IF YES, WHAT?

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. We accept cash, personal check, all major credit cards, and CareCredit.

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 of your visit with the information you provide in this paperwork.

PAYMENTS DUE UPON TREATMENT

*****Please INITIAL highlighted areas*****

_____ For no insurance, payment is expected **in full** at time of treatment.

_____ For participating insurances –**Plan participation verification is required. Applicable out of pocket is to be paid at the time of treatment. This amount is solely an estimate based on available plan verification. You will be responsible for any remaining balance after insurance pays.**

_____ For nonparticipating insurances – a payment of **one-half of your total fee is to be paid at the time of treatment.** We will file the claim as a courtesy to you. You are responsible for the total fee regardless of what insurance pays.

____ **CBCT scans, CBCT scan interpretation (if scan originates from an outside office), intraorifice barriers, interim direct restorations (for GentleWave® use), post space preparations, canal obstructions, incision & drainage procedures, incomplete root canal treatment (fracture discovery), and resin restorations may not be covered benefits with your specific insurance plan. Many insurance plans choose to 'bundle' these codes without transparency. You, as the insured, are responsible for any remaining balance after an insurance claim is filed and resolved.**

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 1 business day 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 choose 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 BEACH ENDODONTICS TO FILE DENTAL INSURANCE ON MY BEHALF AND AUTHORIZE PAYMENT DIRECTLY TO BEACH ENDODONTICS 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**

BEACH ENDODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

______________________________ ____________________
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)