FILL OUT COMPLETELY

MEDICAL AND PERSONAL HISTORY

CONFIDENTIAL

Patient Name: _____ Social Security: _____

Preferred Name: _____ Birthdate: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Home: _____ Work: _____ Cell: _____ Email: _____

Employer: _____ Position: _____ Phone: _____

Spouse/Parent Name: _____ Employer: _____ Phone: _____

General Dentist: _____ Referred By: _____ Dental Insurance: ___ Yes ____ No

Primary Dental Insurance: _____ Employer: _____ Group No: _____

Subscriber Name: _____ Subscriber Soc. Sec. No: _____ Subscriber Birthdate: _____

If insurance is through a retirement plan, who is the previous employer: _____

Secondary Dental Insurance: _____ Employer: _____ Group No: _____

Subscriber Name: _____ Subscriber Soc. Sec. No: _____ Subscriber Birthdate: _____

Emergency Contact Person: _____ Relationship: _____ Phone: _____

Is the present problem due to an accidental injury? _____No ___ Yes, If yes, please give details: _____

_____

HEALTH HISTORY

1. Has the patient ever had any of the following: (Mark yes or no with an "X")

	Yes	No		Yes	No		Yes	No		Yes	No
Asthma	❑	❑	Heart Murmur	❑	❑	Hospitalization	❑	❑	Major Operation	❑	❑
Blood Disease	❑	❑	Heart Trouble	❑	❑	Joint Replacement	❑	❑	Mitral Valve Prolapse	❑	❑
Cancer	❑	❑	Heart Valve/Bypass	❑	❑	Kidney Disease	❑	❑	Rheumatic Fever	❑	❑
Chemotherapy	❑	❑	Hepatitis or Liver Disease	❑	❑	Latex Allergy	❑	❑	Stomach Ulcer	❑	❑
Diabetes	❑	❑	High Blood Pressure	❑	❑	Lung Disease/TB	❑	❑	Venereal Disease	❑	❑
Epilepsy	❑	❑	HIV/AIDS	❑	❑				Osteoporosis/Osteopenia	❑	❑
Ever Taken Phen-fen	❑	❑									

2. Has patient ever had or been told he/she has had:

	Yes	No		Yes	No
Excessive or prolonged bleeding	❑	❑	A reaction to anesthetic injection ("Novocain")	❑	❑
An allergic reaction to any drugs	❑	❑	Slow healing of a wound or incision	❑	❑

3. If female, are you pregnant: ❑ Yes ❑ No

4. List all present or recent medications _____

5. List all medication or drug allergies _____

6. Is there any other information about your health we should know? _____

_____

I hereby grant permission to Dr. Pace or any of his associate(s), to administer anesthetics and to employ such operative, surgical, or technical procedures, including x-rays and photographs as may be deemed necessary or advisable in the diagnosis or treatment in the case of the patient whose name appears above. I also authorize Dr. Pace or any of his employees, associates, or any subsequent dentist, to review or copy any and all information that may be contained in this record, to include but not limited to medical history, treatment, and x-rays.

I also accept full financial responsibility for services rendered by this office and understand that I am to pay in full at the completion of treatment. In the event that I fail to pay the full amount or any agreed upon installment, I agree to pay interest on all monies due at the completionof treatment at the rate of eighteen percent (18%) per annum from that date until paid. If the account is referred to an attorney or suit is filed to collect any sum I owe, I agree to pay costs, collection charges, and reasonable attorneys fees.

_____ _____

Date Signature of Patient, Parent or Guardian

NORTHWEST ENDODONTICS, LTD.

Scott W. Pace, D.D.S.

Welcome to our office. We hope that this information form will answer some of your questions about our office's financial and insurance policies.

Payment is expected at the time service is performed. We accept personal checks with proper identification, Visa, Mastercard, American Express or Discover. The charge for your initial consultation and diagnostic exam will be between $85.00 to $225.00 As insurance company policies vary on coverage for Specialist consultations, **patients may be required to pay for their initial visit regardless of their insurance involvement.**

Regular Indemnity Insurance:
If you have traditional indemnity insurance to help you with payment for your dental treatment, we will be glad to help you receive the benefits from your insurance company. Your insurance company is a third party, and may assist you in payment; we will bill them as a courtesy to you. If your insurance company does not respond within 45 days, we will look to you for payment. **Our treatment is rendered to you, therefore you are the responsible party.**

Most insurance companies have their own schedules of "allowable charges" for each procedure, and they may not be the same as the actual charges in our office. Because of this difference, we ask that you pay **20-50%** of the fee. Based on our experience with your insurance company, we will calculate your co-pay as closely as possible. **Insurance companies will not guarantee phone quotes,** but we can submit a pre-estimate for written verification for you.

Extended Payments:
We do not have "in-house" financing for extended payments. We offer Care Credit, if approved, they offer 6 months, no interest financing. We also offer Citi-Card, If approved, they offer 3 months, no interest financing. **We do not accept post dated checks.**

Collection:
Most of our patients are very conscientious about their accounts, but occasionally we have difficulty with collection. If an account is delinquent and cannot be cleared within 90 days, it will be reported to E-Services, Inc., a collection agency, and will become a part of your credit history until it is cleared. We prefer not to use a collection service, but **if circumstances make it necessary for us to pursue a collection account, an additional 36% will be added to your balance by E-Service, Inc. as a fee for their services.**

If you need to cancel or change your appointment, please give us 24 hours notice. There will be a $50.00 charge for **failed appointments. There will be a $25.00 fee for returned checks.**

Our entire staff is committed to providing you with the best possible dental care, and we will be happy to assist you in any way we can. If you have questions, please don't hesitate to ask.

I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR THE SERVICES RENDERED TO ME BY THE STAFF AT NORTHWEST ENDODONTICS, LTD. I HAVE READ, UNDERSTAND, AND AGREE TO THE POLICIES OUTLINED ABOVE.

Date _____ Signature _____

I authorize the release of any information relating to this claim to my insurance carrier.

Date _____ Signature _____

I hereby authorize payment directly to NORTHWEST ENDODONTICS, LTD. of the group insurance benefits otherwise payable to me.

Date _____ Signature _____

NORTHWEST ENDODONTICS, LTD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

_____

Please Print Name

_____

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:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (please specify)

_____

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