Advanced Root Canal Specialists of Howard County

Richard Fein, DMD • Dov Elman, DDS, MMSc
Kweli Carson, DDS, MS • Yaakov Barak, D.D.S., M.S.
Fazel Fakhari, DDS, MS, PhD

PATIENT INFORMATION

PATIENT NAME ____________________ DATE OF BIRTH ____________

STREET ADDRESS ____________________

CITY, STATE, ZIP ____________________

CELL PHONE ____________________

HOME PHONE ____________________

EMAIL ____________________

OCCUPATION ____________________

IN CASE OF EMERGENCY, NOTIFY

NAME ____________________

PHONE NUMBER ____________________

RELATIONSHIP TO PATIENT ____________________

How did you hear about our practice?

____

Have any of your family members been treated at our practice? (Name and relationship)

____

Is the tooth you are here for today causing you any pain? ☐ YES ☐ NO

If yes, how long have you been having pain with this tooth? ______________________________

Please describe your quality of pain: ☐ SHARP ☐ DULL ☐ THROBBING ☐ ACHING

Duration of pain: ☐ MOMENTARY ☐ LINGERING

Triggers: ☐ HOT ☐ COLD ☐ CHEWING ☐ SPONTANEOUS

Are you currently taking any medication to manage this specific pain? ☐ YES ☐ NO

Have you had any recent dental work in this area? ☐ YES ☐ NO

If yes, when? ______________________________

I have received a copy of this offices Notice of Privacy Practices. (Available to download or view on our website)

______________________________ ____________________

Signature of Patient Date

(Signature of parent or guardian if patient is under the age of 18)

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____
PATIENT NAME

PRIMARY DENTAL INSURANCE	**SECONDARY DENTAL INSURANCE**
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
HOW IS PATIENT RELATED TO SUBSCRIBER? SELF, SPOUSE, DEPENDENT	HOW IS PATIENT RELATED TO SUBSCRIBER? SELF, SPOUSE, DEPENDENT
SUBSCRIBER'S DATE OF BIRTH / SOCIAL SECURITY NUMBER	SUBSCRIBER'S DATE OF BIRTH / SOCIAL SECURITY NUMBER
INSURANCE COMPANY	INSURANCE COMPANY
ID/AGREEMENT NUMBER	ID/AGREEMENT NUMBER
GROUP NAME/NUMBER	GROUP NAME/NUMBER

Every effort is being made to keep down the cost of your dental care. You can help by taking care of your account each visit. Payment in full is expected at the time treatment is rendered. Patients not requiring a root canal will only be required to pay the consultation fee.

We accept the assignment of insurance benefits as a service to our patients who have insurance coverage that will provide payment directly to the provider. We will process and file your dental insurance claim for you. Insurance policies generally cover only a portion of the total treatment cost. We expect payment of your estimated portion at the time of treatment.

Your estimated out of pocket expense today will be __________. Without insurance, todays procedure would cost __________

Please be aware that we cannot guarantee this estimate and that there may be an additional balance after your insurance pays. Statements are prepared when the insurance reimbursement is received, and any remaining balance is due and payable upon receipt. A late payment charge may be imposed only if the balance is not paid 10 days after the statement due date. The late payment charge is 1.5% per month, which is an annual rate of 18% per year. Any check returned by your bank for insufficient funds will be assessed a $25.00 charge. If you have any concerns regarding your coverage, please ask the office manager prior to treatment. Alternative arrangements for payment must be made prior to treatment.

Please circle which payment method you will be using today:

Check Credit Card Cash FSA/HSA Care Credit

I authorize this practice to submit insurance claim forms and receive payment directly from the insurance carrier with the notation "SIGNATURE ON FILE".
I understand and agree that I am completely responsible for complete payment despite the fact that I may have insurance.

______________________________ ______________________
Signature of Patient Date
(Signature of parent or guardian if patient is under the age of 18)

PATIENT MEDICAL HISTORY

NAME: ____

SEX: M F AGE: ________________

Please complete the following questions in order that we may thoroughly diagnose your condition. The medical information you provide for our records is considered strictly confidential.

1. What is your impression of your present general health?

   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Are you required to take antibiotics prior to dental treatment?

   ☐ Yes ☐ No

3. Have you been diagnosed as having AIDS or ARC?

   ☐ Yes ☐ No

4. Have there been changes in your general health within the past year?

   ____

   ____

5. Have you been hospitalized or had a serious illness within the past 5 years?

   ____

6. Are you under the care of a physician for a current problem?

   ____

   ____

7. Have you had abnormal bleeding with previous extractions, surgery or trauma?

8. Please list any medications or drugs (prescribed or over the counter) you take or have taken in the last 6 months:

   ____

9. Have you ever had any ALLERGIC or ADVERSE REACTIONS to: PLEASE CIRCLE **YES(Y) OR NO(N)**:

Y	N	Novocaine	Y	N	Antibiotics	Y	N	Other medication
Y	N	Codeine	Y	N	Penicillin	Y	N	Latex
Y	N	Ibuprofen	Y	N	Erythromycin	Y	N	Previous dental treatment
Y	N	Tylenol	Y	N	Clindamycin			

FOR WOMEN ONLY

If pregnant, number of months: ________________

Are you anticipating pregnancy? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Please be advised that if you take antibiotics, an alternative method of birth control must be used.

PLEASE SELECT **YES (Y) OR NO (N)** TO ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

Y	N	Mitral Valve Prolapse	Y	N	Implant Prosthesis
Y	N	Heart Disease or Condition	Y	N	Artificial Joint (Hip/Knee)
Y	N	Heart Attack	Y	N	Lung Disease
Y	N	Artificial Heart Valve	Y	N	Asthma/Inhaler Use
Y	N	Angina	Y	N	Tuberculosis
Y	N	Heart Murmur	Y	N	Emphysema
Y	N	Bypass Surgery	Y	N	Liver Disease
Y	N	Pacemaker	Y	N	Jaundice
Y	N	Congenital Heart Disease	Y	N	Hepatitis
Y	N	Rheumatic Fever	Y	N	Kidney Trouble
Y	N	High Blood Pressure	Y	N	Renal Dialysis
Y	N	Low Blood Pressure	Y	N	Thyroid Disease
Y	N	Stroke	Y	N	GI Tract Problems
Y	N	Hives or Skin Rash	Y	N	Diabetes/Insulin Use

Y	N	Cancer	Y	N	Blood Disorder
Y	N	Chemotherapy	Y	N	Anemia
Y	N	Radiation Therapy	Y	N	Hemophilia
Y	N	Fainting/Dizzy Spells	Y	N	Sickle Cell
Y	N	Epilepsy or Seizure	Y	N	Transfusion
Y	N	Sexually Transmitted Disease	Y	N	Bruise Easily
Y	N	HIV Positive	Y	N	Arthritis
Y	N	AIDS or ARC	Y	N	Migraine
Y	N	Drug Addiction	Y	N	TMJ Problem
Y	N	Alcoholism	Y	N	Glaucoma
Y	N	Depression	Y	N	Ulcers
Y	N	Psychiatric Care	Y	N	Sinus Problems

Do you have any condition or problem not listed above?

____

____

To my knowledge, all information is complete and accurate. If there is any change I will inform the doctor immediately.

____

SIGNATURE (GUARDIAN'S SIGNATURE IF MINOR) DATE

____

REVIEWED BY DENTIST DATE

____

UPDATE REVIEWED DATE