RIVER HEIGHTS ENDODONTICS, LTD

Welcome to River Heights Endodontics

Our doctors and staff are committed to providing you with the highest level of care. To help us fulfill this commitment, we will need you to fill out some information to enhance our ability to serve and treat you.

In addition to obtaining important information about your health history, our staff would also like to assist you in the submission of your dental insurance claims. To provide this service, we will need to collect information that could be considered sensitive including your policy number, date of birth, and the social security number of the policyholder. If you are opposed to sharing this information due to privacy concerns, we will attempt to answer any questions that you may have about personally filing for direct reimbursement from your insurance company. If elected, patients who decide to proceed with personal filing for direct reimbursement will be asked to pay in full for services rendered at the time of service and insurance payments will be made directly to those patients rather than our office.

If you elect to allow us to assist you with your dental claim processing, we will attempt to contact your insurance company prior to, or during your dental appointment to obtain an estimate of your benefits. Once we have contacted your insurance company, we will ask that your estimated portion be paid at the time of service. If we are unable to reach your insurance company for any reason while you are in our office, we will request that you provide us with specific payment information prior to leaving the office and we will contact you as soon as possible regarding the amount of your estimated payment.

Your 'estimated payment' re ects a simple estimate of your benefits based upon the information made available to us through your insurance company. Although these estimates are intended to be as accurate as possible, it is not uncommon for a credit or debit balance to be present once the insurance has paid. A bill or credit check will be issued in the amount of this difference following a monthly review of account balances.

It is important to understand that your dental benefits policy is a contract between you and your insurance company. We file insurance claims as a courtesy to you and will work with you to obtain the benefits to which you are entitled. We will not become involved in disputes between you and your insurance company other than to supply factual information about treatment provided. Your understanding of our role in this process is important to our professional relationship. Please let our staff or doctors know if you have ay other questions or concerns about the financial policies of the practice or your responsibilities.

RIVER HEIGHTS ENDODONTICS, LTD

Patient Information: Date: _____

Name: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

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

Soc Sec. #: _____ Birthdate: _____

Emergency Contact: _____ Phone: _____

Person Responsible for Account (If a minor): _____

Primary Insurance

Policy Holder's Name: _____ Relationship: _____

Soc Sec. #: _____ Birthdate: _____

Employer: _____ Insurance Company: _____

Secondary Insurance

Policy Holder's Name: _____ Relationship: _____

Soc Sec. #: _____ Birthdate : _____

Employer: _____ Insurance Company: _____

We will request a copy of your insurance card(s) to obtain information regarding your subscriber ID(s) and group number(s), as well as the address of your insurance company(s).

Medical History

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

Referring Dentist: _____

Are you currently taking any medications prescribed by your dentist? If so, please list _____

_____

Primary Physician _____

Are you currently under medical treatment? If so, please describe _____

_____

Are you currently taking any previously unlisted medications? If so, please list or provide staff with a list of your prescriptions _____

_____

Have you had any allergic reactions to the following? If yes, please list what kind and type of reaction, otherwise check No box.

Yes	No		Yes	No	
❑	❑	Local anesthetic (eg., novocaine)_____	❑	❑	Latex _____
❑	❑	Penicillin _____	❑	❑	Sedatives (eg., Valium) _____
❑	❑	Other antibiotics_____	❑	❑	Iodine _____
❑	❑	Sulfa drugs _____	❑	❑	Aspirin _____
❑	❑	Barbiturates (eg., Phenobarbital) _____	❑	❑	Metals_____
❑	❑	Sedatives (eg., Valium) _____	❑	❑	Other _____

Please check the appropriate box regarding whether you have ever had the following?

Yes	No		Yes	No	
❑	❑	High blood Pressure	❑	❑	Blood disease
❑	❑	Low blood pressure	❑	❑	Epilepsy
❑	❑	Heart problems	❑	❑	Kidney disease
❑	❑	Heart valve damage or replacement	❑	❑	Chemical dependency
		*If Yes, do you need a premedication?*_____	❑	❑	Stroke
❑	❑	Joint replacement	❑	❑	Asthma
		*If Yes, do you need a premedication?*_____	❑	❑	Thyroid
❑	❑	Heart Murmur	❑	❑	HIV/Aids
❑	❑	Pacemaker	❑	❑	Back problems
❑	❑	Rheumatic fever	❑	❑	Ulcers
❑	❑	Temporomandibular joint disorder / pain	❑	❑	Glaucoma
❑	❑	Diabetes (type) _____	❑	❑	Hearing loss
❑	❑	Cancer (type) _____	❑	❑	Do you take oral contraceptives?
❑	❑	Hepatitis (type)_____	❑	❑	Are you pregnant? _____

I certify that I have read and understand the above information and the questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ _____

Signature of patient or parent/guardian of minor *Date*

X _____ _____

Doctors Signature *Date*

(Medical History Update Only)

X _____

Signature

_____

Date

MP12262