# PATIENT INFORMATION

PATIENT'S NAME ______________________________ DATE _______________ DATE of BIRTH ____________________
HOME ADDRESS ______________________________ CITY _____________________STATE __________ ZIP __________
SOCIAL SECURITY # ___________________________ HOME PHONE # ___________________ CELL # ____________________
EMPLOYER ______________________________________________________WORK PHONE # ___________________________
SPOUSE'S NAME (PARENT'S NAME if MINOR) ____________________________________________________________
SPOUSE EMPLOYED BY _____________________________________THEIR WORK PHONE # ____________________
IF INSURED; DENTAL INS. CO. & POLICY # ____________________________________________________________
IF SPOUSE'S INS., THEIR SOCIAL SECURITY # ____________________________ DATE of BIRTH _______________________
REFERRED BY DR. __________________________________________E-mail ___________________________________________

## ╬ MEDICAL HISTORY ╬

**Do you have or have you ever had any of these conditions?**
(Please Check Box if Yes)

- □ MITRAL VALVE PROLAPSE
- □ HEART DISEASE / ATTACK
- □ HEART MURMUR
- □ RHEUMATIC FEVER
- □ RHEUMATIC HEART DISEASE
- □ PROSTHETIC ( ARTIFICIAL ) HEART VALVE
- □ HIGH BLOOD PRESSURE
- □ LOW BLOOD PRESSURE
- □ CONGENITAL HEART DEFECT
- □ STROKE
- □ ANGINA ( CHEST PAIN )
- □ OTHER HEART PROBLEMS
- □ TUBERCULOSIS
- □ EMPHYSEMA
- □ ASTHMA
- □ SINUS TROUBLE / ALLERGIES
- □ ARTHRITIS
- □ BONE DISORDERS
- □ PROSTHETIC ( ARTIFICIAL ) JOINT REPLACEMENT

- □ ACQUIRED IMMUNE DEFICIENCY SYNDROME ( AIDS )
- □ VENEREAL DISEASE
- □ DRUG DEPENDANCY
- □ DIABETES
- □ THYROID DISORDERS
- □ STEROID (CORTISONE ) THERAPY
- □ ANEMIA ( LOW BLOOD )
- □ BLOOD TRANSFUSION
- □ BLEEDING PROBLEMS
- □ ANTICOAGULANTS ( BLOOD THINNERS )
- □ LEUKEMIA
- □ EPILEPSY
- □ FAINTING SPELLS
- □ SEIZURES
- □ STOMACH or INTESTINAL ULCERS
- □ HEPATITIS ( JAUNDICE )
- □ LIVER DISEASE
- □ KIDNEY DISEASE
- □ CANCER, TUMOR

**Are you currently taking any medications? □ YES □ NO**
Please list: ________________________
____________________________________
____________________________________

**Have you ever had an allergic or unusual reaction to any of following?**
**□ YES □ NO**
□ Penicillin □ Aspirin
□ Local Anesthetic
□ Codeine □ **Others ( Please List )**
____________________________________
____________________________________

**Are you pregnant? □ Yes □ No**

**Have you had surgery in the past?**
**□Yes □ No** Reason: ________________
____________________________________
____________________________________

**Is there any other information we should know concerning your health?** _____________________________________________
**Are you currently under the care of a physician? □ Yes □ No** If so why? ___________________________________________
**Physicians name** ____________________________________________________________________________

## OFFICE PAYMENT POLICY AND INFORMED CONSENT

The best Patient/Doctor relationships are maintained when there is a complete understanding of the treatment being rendered and the fees being charged for that treatment. To avoid misunderstandings concerning payment of these fees please note that **payment is required in full** on or **prior** to the completion of treatment , or **other satisfactory arrangements ( such as Dental Insurance )must be made in advance**. We prefer not to send out monthly statements. In the event an account is turned over to collections, the patient or person responsible for the account agrees to pay all attorney fees, court costs, and any other reasonable costs associated with the collection process.

**Please indicate the method of payment to be used:** □ I will pay in full now, if treatment is completed at this one visit.
□ I will pay half now and the balance at the 2nd visit if two visits are required to complete the treatment.
□ I will charge to my: □VISA □ MasterCard □ Discover □ AmExpress □ CareCredit
□ I have Dental Insurance and will pay $200.00 if we do treatment or $65.00 for the exam & x-ray at the initial appt. **After my insurance has made their payment, I will pay the remaining balance due for any services/charges not covered by my insurance policy**, or I will be reimbursed for any over payment. I also authorize my insurance benefits to be paid directly to Dr. Bingham's office.

**I understand Root Canal Therapy is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal Therapy has a very high degree of clinical success, it is a biological procedure and requires healing by the body. Therefore it can not be guaranteed. Occasionally, a tooth which has had Root Canal Therapy may require re-treatment, surgery, or even extraction.**

**I also understand that only the Root Canal Therapy is performed in this office. The permanent (outside) restoration (filling, crown, etc.) will be done by my regular Dentist.**

**Please give 24 hour notice if unable to keep your scheduled appointment; otherwise there may be an additional fee charged.**

**Signature of Patient (Parent if minor)** ____________________________________________ **Date** ___________________