ADVANCED ENDODONTICS OF BUFFALO

3993 Harlem Road
Amherst, NY 14226

CONFIDENTIAL

PATIENT INFORMATION

Name: _____ Birthday:_____ Soc. Sec #_____

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

Home Phone: _____Work Phone:_____ Cell Phone/Pager: _____

Whom may we thank for referring you? _____ General Dentist:_____

Person to contact in case of emergency:_____ Telephone No.: _____

RESPONSIBLE PARTY FOR A MINOR

Name:_____ Relationship to patient: _____

Address: _____ Soc. Sec #:_____

DOB: _____ Contact Phone Number: _____

DENTAL INSURANCE INFORMATION **Please allow us to photocopy your ID card**

Name of policyholder: _____ Relationship to patient: _____

Birthday: _____ Soc. Sec. #: _____ Date Employed:_____

Name of Employer:_____City/State/Zip:_____

Insurance Company:_____Group No.:_____

Policyholder Address:_____City/State/Zip:_____

ADDITIONAL INSURANCE: Name of policyholder: _____ Relationship to patient: _____

Birthday: _____ Soc. Sec. #: _____ Date Employed:_____

Name of Employer:_____City/State/Zip:_____

Insurance Company:_____Group No.:_____

Policyholder Address:_____City/State/Zip:_____

SIGNATURE ON FILE

We are required to have your signature on file for several reasons.

1. Acknowledgment of receipt of our notice of Privacy Practices.
2. Process any insurance claims: *By signing below, you authorize and request payment of healthcare benefits otherwise payable to you to be made directly to Advanced Endodontics of Buffalo, PC. Insurance benefits are an estimate and do not guarantee payment, any balance remaining after insurance has made their payment is the patients responsibility. Our office participates with the following companies: NOVA (Azeros), Aetna, BC/BS, Cigna, CSEA, DeltaDental, Dental Pay Plus, Dentamax, GHI, Guardian, Health Economics Group, Metlife, Promoco, United Concordia, and Univera. As a courtesy to you, we will submit all claims and necessary documents to your insurance company(s). You authorize our office to process any insurance appeals that may be required.*
3. To obtain payment and financial responsibility for the account: *Payment is required at each treatment visit; this includes the estimated portion not covered by insurance. The patient is responsible for all charges, including collection or attorney fees if applicable, on the account. Our office accepts the following forms of payment:*

   _____Cash_____Check Visa/MasterCard/Discover_____
   Card Number/Expiration
4. Communicate with other health providers: *After treatment is complete, a letter will be sent to your restorative dentist with copies of your radiographs. We also may need to communicate with your physician.*

_____ _____

Signature of Patient or Parent/Guardian Date

PATIENT MEDICAL/DENTAL HISTORY

Physician: _____ Office Phone: _____ Date of Last Exam: _____

****Please check Yes or No where applicable****

	Yes	No	N/ A
1. Are you under medical treatment now?	☐	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐	☐
3. Are you taking ANY Medication(s) including non-prescription medicine? If Yes, what Medicine(s) are you taking? _____ _____	☐	☐	☐
4. Do you use cocaine or other drugs? *(some drugs can have a fatal reaction with our anesthetics)*	☐	☐	☐

5. Are you allergic to or have you had any reactions to the following:

Yes	No		Yes	No	
☐	☐	a) Local Anesthetics	☐	☐	e) Sulfa drugs
☐	☐	b) Epinephrine	☐	☐	f) Aspirin
☐	☐	c) Latex	☐	☐	g) Iodine
☐	☐	d) Penicillin	☐	☐	h) Other _____

6. Do you or have you had any of the following conditions?

Yes	No		Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Joint Replacement	☐	☐	Cancer
☐	☐	Angina/Chest pain	☐	☐	Asthma	☐	☐	Radiation Therapy
☐	☐	Heart Disease	☐	☐	Thyroid Problems	☐	☐	Fainting/Seizures
☐	☐	Stroke	☐	☐	Arthritis	☐	☐	Kidney disease
☐	☐	Cardiac Pacemaker	☐	☐	Diabetes	☐	☐	Liver Disease
☐	☐	Heart Murmur	☐	☐	Hepatitis A, B, C	☐	☐	Sexually Transmitted
☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐	AIDS or HIV infection
☐	☐	Rheumatic Fever	☐	☐	Stomach Ulcers	☐	☐	Other _____

7. Women Only:	Yes	No
a. Are you pregnant or think you may be pregnant?	☐	☐
b. Are you taking birth control pills?	☐	☐

PATIENT DENTAL HISTORY

	Yes	No
1. Are your teeth sensitive to cold or hot liquids or foods?	☐	☐
2. Are your teeth sensitive to sweet or sour liquids or foods?	☐	☐
3. Do you have tooth pain upon biting or release from biting?	☐	☐
4. Do you clench or grind your teeth?	☐	☐
5. Have you had any temporal mandibular joint pain or clicking?	☐	☐
6. Do you have any sores or lumps in your mouth today?	☐	☐

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION, TO THE BEST OF MY KNOWLEDGE; THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

_____ _____

Signature of Patient or Parent/Guardian Date