Dr. Simpson and his staff Welcome you to Buckeye Endodontics

PATIENT INFORMATION:

Full Name:_____ Birth date:_____SS#_____

Address:_____City_____ State_____ Zip_____

Home ph #_____Work_____ Cell_____

General Dentist _____Who referred you to our office?_____

Emergency Contact Name:_____Phone #_____Relationship_____

IF THE PATIENT IS A **MINOR**- Who is the legal guardian/parent?

Name of Parent/guardian:_____ Address:_____

City_____State_____Zip_____Contact Phone # (_____)_____

Dental Insurance information: **(We may already have this on file, prior to your appointment)**

Primary Insurance Company's name:_____ Phone # _____

Subscribers Name:_____ DOB_____ SS or ID_____

Secondary Insurance _____ Phone #_____

Subscribers Name: _____ DOB_____ SS or ID_____

ON FILE

POLICIES OF BUCKEYE ENDODONTICS: PLEASE READ OVER POLICIES BELOW

- **Appointments:** There is a **$50.00 charge for a less than 24 hr notice of cancellation or rescheduling**. If you are more than 15 minutes late, we may have to reschedule you. If you reschedule or cancel with less than 24 hr notice multiple times or if you are late multiple times, we may have to dismiss you as a patient.
- **Privacy Policy:** Our privacy policy (HIPAA) is available at the check in desk. If you do not want any of your private information shared with a spouse or other relative please inform us in writing asap.
- **Financial: Co pays are due at time of treatment.** The account balance whether the insurance denies coverage or not is the responsibility of the patient or parent/guardian. If a balance goes 30 days unpaid an interest charge will be added & after 60 days your account will be sent to pre-collections or collections. CareCredit.com is the only payment plan we offer. **You have to apply for CareCredit prior to your treatment appointment.**
- EVALS ARE NOT ALWAYS COVERED, IF YOU HAD AN EVALUATION AT YOUR GENERAL DENTIST THE SAME YEAR, YOU MAY HAVE A BALANCE.

*By Signing below, I acknowledge that I have read the privacy policy, appointment policy and financial policy. I also agree to release my treatment information to my insurance companies, my general dentist and any relatives that may call to ask about my treatment at this office. I am aware Buckeye Endodontics will communicate with my general dentist by email or mail to inform them of any treatment I may have done today or in the future. I authorize my insurance company to pay Buckeye Endodontics any insurance benefits for treatment that I have done at this practice. I give my consent to have Buckeye Endodontics examine, x-ray and treat my Endodontic condition. We strive to keep all crowns intact during treatment . Sometimes the crown will have to be replaced due to unforseen circumstances. I understand there are risks with having endodontic treatment through my crown, if one is present.

SIGNATURE OF PATIENT or the GUARDIAN OF PATIENT_____Date_____

****PLEASE FILL OUT THE BACK OF THIS SHEET ALSO** → → → → → → → →

Buckeye Endodontics asks for your medical information and medications in attempt to prevent any interactions or negative affects with any treatment or medications you may be given at our office. You may also have to follow up with your pharmacist or general physician.

Patient Medical History (confidential)

Name of Medical Physician (if known) _____ Phone #_____

Have you had any serious illness, surgical procedures, hospitalization in the past 7 years? Y or N
If yes Please explain:_____

_____

Are you under the care of a physician for a medical condition or a serious illness?
If yes Please explain:_____

Are you taking any medications? Please list :_____

_____

***ARE YOU ALLERGIC TO:**
Circle **yes** if you are

LATEX	Yes
Clindamycin	Yes
Penicillin/Amox	Yes
Sedatives,Barbiturates	Yes
Aspirin or Advil	Yes
Vicodin/Tylenol #3	Yes

Please list the names of other drugs you are allergic to ***(rash,seizures)*** upset stomach is not an allergic reaction.
**_____

Are you diabetic	Yes	No
If so, did you eat today	Yes	No
Do you have kidney problems		Yes
Do you have epilepsy or seizures		Yes
Do you have a lung disease		Yes
Do you have asthma		Yes
Do you have a sexually transmitted Disease		Yes
Do you have Aids or are HIV positive		Yes
Do you have or ever had Hepatitis A, B or C		Yes
Do you or have you had Tuberculosis		Yes

Do you need a PRE-MEDICATION prior to dental treatment due to a recent joint replacement or a heart condition? Yes No

If yes, did you take your PRE-MED? Yes No

Can you lie flat on your back? Yes No
If no, please explain why-_____

_____

Do you have Rheumatism or arthritis ? Yes No
Are you pregnant or suspect you may be? Yes No

Have you ever had/experienced the following?

Heart Attack	Yes
Heart Murmur	Yes
Heart Surgery	Yes
Coronary artery disease	Yes
Angina (chest pain)	Yes
Palpitations	Yes
PACEMAKER	Yes
High Blood pressure	Yes
MVP-Mitral Valve Prolapse	Yes
Rheumatic fever	Yes
Blood Transfusion	Yes
Do you have an artificial joint	Yes
Do you have an artificial heart valve	Yes
Are you currently taking blood thinner	Yes

Do you have an ongoing dental condition that is not necessarily related to today's visit? Such as: Bleeding gums, periodontal disease, TMJ, grinding, clenching, blisters, ulcers, herpes, locking of the jaw, sensitive gums or teeth? **If so please list the ones that apply.**

_____

_____

I certify that I have answered the questions correctly. I allow the doctors at Buckeye Endodontics to treat me for my endodontic needs.

Signature_____ Date _____