Welcome

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

cell # ________________

Patient Information

Name ______________________ (Last Name) ______________________ (First Name) ______ (Middle Initial) Soc. Sec. # ______________

Address ______________________ Home Phone ______________

City ______________ State ______ Zip ______ Email ______________

Sex ☐ M ☐ F Age ______ Birthdate ______________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by ______________________ Occupation ______________

Business Address ______________________ Business Phone ______________

Whom may we thank for referring you? ______________________

Notify in case of emergency ______________ Home Phone ______________ Work Phone ______________

Cell Phone ______________ Business Email ______________

Primary Insurance

Person Responsible for Account ______________ (Last Name) ______________ (First Name) ______ (Middle Initial)

Relation to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address (if different from patient) ______________________ Home Phone ______________

City ______________________ State ______ Zip ______

Cell Phone ______________________ Email ______________

Person Responsible Employed by ______________________ Occupation ______________

Business Address ______________________ Business Phone ______________

Business Email ______________________

Insurance Company ______________________ Phone ______________

Contract # ______________ Group # ______________ Subscriber's # ______________

Name(s) of other dependents under this plan ______________________

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________ Relation to Patient ______________ Birthdate ______________

Address (if different from patient) ______________________ Soc. Sec. # ______________

City ______________ State ______ Zip ______ Home Phone ______________

Cell Phone ______________________ Business Phone ______________

Subscriber Employed by ______________________ Business Email ______________

Insurance Company ______________ Phone ______________ Insurance Email ______________

Contract # ______________ Group # ______________ Subscriber's # ______________

Name(s) of other dependents under this plan ______________________

CONFIDENTIAL HEALTH HISTORY

Patient Name: ______________________________ Date of Birth: ____________________

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: ______________________________
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: ______________________________
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: ______________________________
4. Yes / No Are you being treated by a physician now? If YES, explain: ______________________________
   Date of last medical exam? ______________ Reason for exam: ______________
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: ______________________________
   Date of last dental exam: ______________ Name of last treating dentist: ______________
6. Yes / No Are you in pain now?
   If YES, explain: ______________________________

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	Cosmetic surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others: ______________________________

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin

Please list all prescription medications: ______________________________

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? ______________________________

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: ______________________________

____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: ______________________________

Yes / No Have you ever taken Fen-Phen? If YES, when: ______________________________

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: ______________________________ Date: ______________________________

Physician's Name: ______________________________ Phone Number: ______________________________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ ______________ ______________________________ ______________

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS

(AS 6/2009)

SAN CARLOS ENDODONTICS

**ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")**

Last Updated September 1, 2013

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices.**

____
Patient Name (Please Print)

______________________________ ______________________________
Patient Signature Date

OR

____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: ______________________

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:____

______________________________ ______________________________
Staff Member Signature Date

San Carlos Endodontics

1028 Laurel Street, San Carlos, CA 94070
Phone: 650-595-3722
email: info@sancarlosendodntics.com

Informed Consent for New Patients

Dear Patient,

Please complete this ***Informed Consent for New Patients*** and initial all items as requested.

Endodontic Exam/Consult:

An endodontic evaluation/examination is the only way to assess the chief complaint or the tooth/teeth health in the area that is recommended by your General Dentist. We use the findings to rule out diseased tissues allowing the Endodontist to diagnose the oral infection or disease process accurately.

Radiographs/X-rays:

Radiographs are used to supplement the chief complaint, signs and symptoms associated with the diseased or problematic tooth area. We use the x-rays sent by your dentist and often times make an updated film or an angled film to see the area in more of a 3-dimensional way. The radiographs reveal many tooth related conditions, complex anatomy, and may show other non-tooth related issues. Radiographs are essential in order for the Endodontist to give full comprehensive advice on the diagnosis of the tooth area and give a prognosis of the treatment options.

I understand that Endodontic treatment, as is any dental procedure not 100% guaranteed. I consent to Examination, Radiographs and tests needed for diagnosis as described above.

Patient signature________________________________ **Date**____________

Witness (Doctor or Staff)__________________________

San Carlos Endodontics

1028 LAUREL STREET | SAN CARLOS CA, 94070 | (650) 595-3722

Written Financial Policy

Thank you for choosing San Carlos Endodontics. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

1) Cash, Check, Visa, MasterCard, American Express or Discover Card

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment in full with cash, check or credit card on the same day of treatment

2) We also offer in-house financing. Two monthly payments billed directly to your credit card for your convenience.

3) Third party financing[1]; convenient monthly payment options available.

Please note:

San Carlos Endodontics requires payment upon the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment less your co-pay and deductible.[2]

A fee of $50 is charged for patients who miss or cancel more than 1 time in a calendar year without 48-hour notice.

San Carlos Endodontics charges $30 for returned checks.

I consent to SCE using my cell phone number to __ call and/or __ text and receiving email communications regarding appointments, treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

My cell # is ________________. **Initial:** ____ My email is ____________________________. **Initial:** ____.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.