

Any other diseases or problems?

Have you ever had an unusual reaction to latex, an anesthetic, or drug such as Penicillin, Erythromycin, Novacaine, Codeine, Aspirin, Sulfa, or any other medications? * Yes / No

If yes, please explain:

What medications are you taking at present?

Have you taken Aspirin or Ibuprofen in the last 72 hours? * Yes / No

If yes: Aspirin? Ibuprofen? How many?

Women - Are you pregnant? Yes / No If yes, what month?

THE PURPOSE of endodontic treatment or root canal treatment is to save the tooth rather than remove it. Although treatment has a high degree of success, it cannot be guaranteed. Occasionally, a tooth that has had a root canal treatment may require re-treatment, surgery or even extraction.

Treatment is usually a non-surgical procedure, but in some cases, a surgical approach is necessary. Before any treatment is begun the reason(s) will be explained, including alternative modes of therapy. Occasionally, pre-medication may be indicated. This will be discussed in advance.

PLEASE NOTE: The fee will not include a permanent filling or crown on the tooth. You must return to your general dentist to have that treatment completed.

I consent to necessary treatment and authorize the release of any information needed for further treatment. *

Nov 10 2007

*Signature of Patient (Custodial Parent/Guardian of Minor)** *Date*

**Please verify my insurance. (*Please fill out all insurance information)
Contact me regarding my insurance.
I do not have insurance.**

Primary Dental Insurance

Name of Insured Person Relationship to
(Employee): Patient:
Member ID: Date of Birth (m/dd/yyyy): Jan ,
Employer/Retired Length of
From: Employment:
Insurance Group Insurance
Company: #: Phone:
Address: City: State: AZ Zip:

Secondary Dental Insurance

Name of Insured Person (Employee): Relationship to Patient:

Member ID: Date of Birth (m/dd/yyyy): Jan ,

Insurance Company: Group #: Insurance Phone:

Address: City: State: AZ Zip:

I hereby authorize the provider to file my insurance and benefits to be paid directly to the provider.

I also understand that when my particular insurance is filed:

1. I authorize the release of any information related to my claim to my insurance company.
2. I am ultimately responsible for the balance on my account for any professional services rendered regardless of the amount my insurance pays toward my account. **We ask that patients with insurance pay estimated portion of the cost of treatment; at the time service is received.**
3. Any balance not paid by my insurance will be due within two weeks of the statement date, a **LATE FEE** and/or **SIMPLE INTEREST CHARGE** may be added to the account. The **INTEREST CHARGE** will be a periodic rate of **1.5%** per month, which is an **ANNUAL PERCENTAGE RATE** of **18%** applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

If patient is under the age of 18 years old, please complete the following:

Responsible Party: SSN:

Street Address City State Zip

AZ

Home Phone Work Phone Relationship to Patient

I understand that I am ultimately responsible for fees incurred at the time of service.*

Nov 10 2007

Signature of Patient (Custodial Parent/Guardian of Minor)* **Date**

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