Welcome to

Patient Information

Last Name_____**First Name**_____**MI**_____

Date of Birth_____**Social Security Number**_____
Gender: **Male** _____ **Female** _____
Please circle one: Single Married Widowed Divorced Separated Domestic Partner

Email Address: _____

Address_____

City_____**State**_____**Zip**_____

Home Telephone( ) **_____Work Telephone ( )**_____

Cell Phone( )_____**Best place to reach you**_____

Occupation_____ **Employed by**_____

Emergency Contact_____ **Phone ( )**_____

Referring / General Dentist_____

Pharmacy:_____

Pharmacy Phone Number:_____

Primary Dental Insurance Information
Insurance Company Name_____

Insurance Address_____

Telephone(___)_____**Group Number**_____

Name of Insured_____**Social Security#**_____

Insured DOB_____**Employer**_____

Secondary Dental Insurance Information
Insurance Company Name_____

Insurance Address_____

Telephone(____)_____

Name of Insured_____**Social Security#**_____

Insured DOB_____**Employer**_____

Forward any information to: office@bucktownendo.com

Medical Information

Have you ever had (Please Circle Yes or No)

Heart Trouble------- Yes No

Rheumatic Fever------Yes No

Convulsions--------- Yes No

Bleeding Problems-Yes No

Asthma---------- Yes No

High Blood Pressure-Yes No

Thyroid Problems –Yes No

HIV----------Yes No

Nervous Disorders ---Yes No

Anemia----------Yes No

Hepatitis----------Yes No

Diabetes----------Yes No

Are you currently a smoker----------Yes No

Are you currently taking or have taken bisphosphonate medications such as Actonel, Fosamax or Zometa, within the past twelve years?---------- Yes No

Have you had a hip, joint, or valve replacement?---------- -Yes No
If so, when? _____

Does your physician tell you to premedicate with an antibiotic before dental appointments for any medical condition?---------- -Yes No

Have you taken any medicines for your heart or high blood pressure?--------- -Yes No

Do you have a pacemaker?---------- Yes No

Are you now taking any medicine, drug, alcohol or pills for any purpose?-------Yes No
If so, what?_____

Are you allergic to any food, medicine, or drug?----------Yes No
If so, what?_____

Are you allergic to local anesthetic?----------Yes No

Are you allergic to latex?----------Yes No

Have you been under the care of a physician during the last year?----------Yes No

Is there any condition concerning your health the doctor should be told?--------Yes No
If so,
what_____

Have you ever had Root Canal Therapy before----------Yes No

Women Are you pregnant or breast feeding?----------Yes No

I certify that these statements concerning my health are correct to the best of my knowledge

Signed_____ Date_____

Standard Fees

Anterior (Front teeth)…… $1,326.00 and up
Bicuspids (middle teeth)……. $1,441.00 and up
Molars (back teeth) ……. $1,590.00 and up
Consultations …… $225.00 and up
Cone Beams/CBCT Scan…… $300.00
Retreatments**: Additional Fees**

The above fees do not include the final restoration by your general dentist. You will leave our office with a **temporary filling** after your root canal therapy. **All posterior teeth need to be restored with a full coverage crown**. You are responsible to follow-up with your dentist after treatment is completed by our office. There will be a **$45.00** charge for all missed appointments.

Our Financial Policy

Self-Pay

To keep billing costs to a minimum, we ask that the services provided be paid in full by the time they are completed.

With insurance

We will gladly bill your dental insurance company for any charges incurred in our office. We do require those with insurance to provide us with sufficient information to bill your insurance company. Any benefit information we obtain from your insurance company is an estimate and only done as a courtesy.

You are ultimately responsible for any balance on your account.

To keep billing costs to a minimum, we require you to leave a credit card on file with our office. For your estimated portion you may choose your method of payment: Cash or credit card. Your estimated portion is due the day services are rendered. Please provide our office with a credit card number so we may resolve any balance on your account or credit your account for any overages due to you.

___Visa ___MC ___Discover ___Care Credit

Card Number _____ Exp____ /____

Signature Code: _____

I authorize Bucktown Endodontics to charge my credit card for any balance or refund any overages on my account.

All patients please read the following:

I have read and understand the above policies. I authorize the release of any information to my insurance company pertaining to any service rendered. I also authorize payment to be made directly to the dentist. I am aware that any unpaid balance after work is completed is subject to an 18% finance charge if it becomes delinquent. Any collections fees for delinquent accounts is the responsibility of the patient, fees equal 1/3 of the balance.

Date_____ Signed_____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____.
Print Patient Name _____
Signature _____
Relationship to Patient _____

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