Savannah Endodontic Associates, LLC

Please Print

PATIENT INFORMATION

PATIENT

LAST NAME DR. MR. MRS. MISS	FIRST NAME	MIDDLE	PREFERRED NAME/NICKNAME

PHYSICAL ADDRESS	CITY	STATE	ZIP
MAILING ADDRESS-IF DIFFERENT FROM ABOVE	CITY	STATE	ZIP

TELEPHONE #	WORK #	CELL #
SOCIAL SECURITY #	DATE OF BIRTH	EMAIL ADDRESS
EMPLOYED BY		OCCUPATION

SPOUSE OR GUARDIAN NAME	EMPLOYED BY	OCCUPATION

SOCIAL SECURITY #	DATE OF BIRTH	WORK #	CELL #	EMAIL ADDRESS

NAME OF FRIEND OR NEIGHBOR WHO CAN REACH YOU IN CASE OF EMERGENCY_____

ADDRESS_____PHONE_____

RESPONSIBLE PARTY

WHOM MAY I THANK FOR REFERRING YOU?

_____
NAME

_____
ADDRESS CITY STATE ZIP

WHO IS YOUR GENERAL DENTIST?

_____
NAME

_____
ADDRESS CITY STATE ZIP

IS PATIENT COVERED BY **DENTAL** INSURANCE
IF SO

_____
NAME OF INS. CO. (PRIMARY) POLICY OR ID# SUBSCRIBER NAME

_____
NAME OF INS. CO. (SECONDARY) POLICY OR ID# SUBSCRIBER NAME

PAYMENT AGREEMENT

❑ **Credit Card** ❑ **Check** ❑ **Cash** ❑ **Care Credit**

I certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, **I am responsible for payment of services.** I also hereby agree that if my bill has to be turned over to a third party collection agency for non-payment, there will be a collection fee of 35% added to my bill. This is pursuant to Georgia Statutory law "O.C.G.A.-13-1.11"

I understand root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, loss of dental prosthesis or extraction.

I also understand that only the root canal treatment is to be performed at this office. The permanent (outside) restoration (filling, onlay, crown, bridge, etc.) will be done by my general dentist within eight weeks.

I hereby grant authority to SAVANNAH ENDODONTIC ASSCOCIATES, LLC and/or to the dentist(s) in charge of the care of the patient whose name appears above, to administer treatment, anesthetics, and to perform such procedures which may be deemed necessary or advisable in the diagnosis and treatment of this patient.

_____

Authorization must be signed by nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

PATIENT / LEGALLY RESPONSIBLE PERSON:_____

DATE:_____ WITNESS:_____

(OVER)

Savannah Endodontic Associates, LLC

MEDICAL HISTORY

PLEASE PRINT

CONFIDENTIAL

Date_____

Patient's Name _____

Present Complaint or Request: _____

Is the present problem due to an accidental injury? YES ❑ NO ❑ When? _____

How and when did the accident occur? _____

In the following questions, answer yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Are you now under the care of a physician / cardiologist? ..... YES ❑ No ❑

If so, what is the condition being treated? _____

The name and phone number of my physician is _____

Does your medical doctor require you to **pre-medicate** with antibiotics prior to dental procedures? ..... YES ❑ No ❑

If so, what is the condition being covered? Hip or Joint Replacement ❑ Heart Valve❑ Other❑ Date: _____

DO YOU HAVE OR HAVE YOU HAD:

Asthma ..... YES ❑ No ❑
Arthritis ..... YES ❑ No ❑
Diabetes ..... YES ❑ No ❑
Hepatitis/ Liver Disease ..... YES ❑ No ❑
HIV/AIDS ..... YES ❑ No ❑
Immune Deficiency ..... YES ❑ No ❑
Inflammatory Rheumatism ..... YES ❑ No ❑
Kidney Disease ..... YES ❑ No ❑
Sinus Condition ..... YES ❑ No ❑
Stomach Ulcers ..... YES ❑ No ❑
Thyroid Disease ..... YES ❑ No ❑
Malignancies (Cancer) ..... YES ❑ No ❑
Chemo/Radiation Therapy ..... YES ❑ No ❑
Psychiatric Treatment/Mental Depression ..... YES ❑ No ❑
Have you ever had an addiction or problem with alcohol or other drugs? ..... YES ❑ No ❑

Abnormal Heart Condition:
Heart Surgery ..... YES ❑ No ❑
Heart Valve Replacement ..... YES ❑ No ❑
Chest Pain/Angina ..... YES ❑ No ❑
Heart Attack ..... YES ❑ No ❑
Stroke ..... YES ❑ No ❑
Seizures/Epilepsy ..... YES ❑ No ❑
Hemophilia ..... YES ❑ No ❑

Blood Pressure: High _____ Low _____ Normal _____

Women: Are you pregnant? ..... YES ❑ No ❑
Are you taking birth control pills? ..... YES ❑ No ❑
Are you breast feeding? ..... YES ❑ No ❑

Have you ever had any serious complications with any previous dental treatment? ..... YES ❑ No ❑

If so, explain _____

_____

Do you have any disease, condition, or problem not listed above that you think I should know about? ..... YES ❑ No ❑

Please list names of all current medications: _____

_____

Are you presently **TAKING** any of the following:
Antibiotics or sulfa drugs ..... YES ❑ No ❑
Aspirin ..... YES ❑ No ❑
Anticoagulants (blood thinners) ..... YES ❑ No ❑
Medicine for high blood pressure ..... YES ❑ No ❑
Cortisone (steroids) ..... YES ❑ No ❑
Tranquilizers ..... YES ❑ No ❑
Insulin, tolbutamide (orinase) or similar drug .... YES ❑ No ❑
Digitalis or drugs for a heart condition ..... YES ❑ No ❑
Nitroglycerin ..... YES ❑ No ❑
Bone-building drugs (Fosamax, Boniva, etc.) ... YES ❑ No ❑

Are you **ALLERGIC** or have you reacted adversely to:
Local anesthetics ..... YES ❑ No ❑
Penicillin ..... YES ❑ No ❑
Other antibiotics ..... YES ❑ No ❑
Barbituates, sedatives, or sleeping pills ..... YES ❑ No ❑
Aspirin ..... YES ❑ No ❑
Bleach ..... YES ❑ No ❑
Latex ..... YES ❑ No ❑
Other ..... YES ❑ No ❑

The above information that I have provided is true and correct to the best of my knowledge.

Thank You! ***X*** _____

Signature of Patient or Legally Responsible Person

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