# PATIENT REGISTRATION INFORMATION **For the office of Bowling Green Endodontics, Inc.**

Date ____________________ General Dentist ______________________________

Name ______________________________________________________________________
(First) (MI) (Last)

**Welcome to our practice!**
Thank you for selecting Bowling Green Endodontics. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance – we will be happy to help! This information is confidential

---

Home Address ________________________________ City _________________ State______ Zip ____________

Birthdate _______________ Home Phone ________________________ Work Phone ______________________

E-Mail ___________________________________________________ Cell Phone __________________________

Do you prefer to receive calls at: __ Work __ Home __ Cell __ Any

Are You: __ Minor __ Single __ Married __ Divorced __ Widowed

Employer __________________________________ Occupation _____________________________

Business Address ___________________________ City ___________________ State ______ Zip ____________

Spouse Name ____________________ Employer _____________________ Work phone ___________________

Parent Employer (if Minor) ______________________________ Work Phone ____________________________

Emergency contact ____________________________________________ Phone __________________________

**Insurance Information (Please complete all that is applicable)**

Name of Insured __________________________________ Relationship to Patient _________________________

Birthdate ____________________ SS # ________________

Insurance Company __________________________________ Group # ________________ ID # ______________

Secondary Insurance Company ___________________________ Group # ______________ ID# ______________

---

**Authorization, Release, and Agreement to Pay for Services Rendered**
I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners. I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services, but that I am still responsible for paying the entire remaining balance of my account. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X________________________________________________________________________________
Signature of Patient or Parent/Guardian if Minor Date

# PATIENT HEALTH HISTORY

Patient Name ______________________________________________ Birthdate ________________________

Your Physician's name _________________________________ Physician's phone # ______________________

Emergency Contact ___________________________________ Contact's phone # _______________________

Are you having any pain or discomfort at this time : Yes No

**Please circle any of the following you have had or have at the present time**

Heart Condition
Heart murmur
Artificial heart valve
High Blood Pressure
Rheumatic Fever
Blood Transfusion
Heart pacemaker
Heart surgery
Heart Attack
Stroke
Anemia
Alcohol/Drug addiction
Venereal Disease

Shortness of Breath
Lung Disease
Asthma
Kidney trouble
Diabetes
Thyroid Disease
Hepatitis
Liver Disease
Artificial Joint
Emphysema
Tuberculosis (TB)
Cold Sores
Bacteremia

Radiation to the head/neck
Epilepsy/Seizure
Sinus Trouble
Sickle Cell Disease
HIV/AIDS
Mental Health treatment
Cortisone/Steroid medication
Arthritis
Pain in Jaw Joints/TMJ
Fainting or Dizziness
Glaucoma
Cancer or Tumor

Please list any disease or conditions not shown above__________________________________________________

Please list any medications you are currently taking ___________________________________________________

Please list any items or medicines to which you have reactions or allergies _________________________________

Have you ever been hospitalized or had surgery? Explain _______________________________________________

Are you required to take premedication prior to dental treatment? ………………………………………………. Yes No

Have you ever taken any drugs for osteoporosis or other bone disorder (i.e. Fosamax, Actonel)? ………… Yes No

Have you ever taken any IV forms of bisphosphonates (i.e. Aredia, Zometa)? ………………………………… Yes No

Are you currently taking any anticoagulants (blood thinners)? ……………………………………………….. Yes No

Is this treatment a result of an injury, trauma, or accident? ……………………………………………………… Yes No

Are you nervous or concerned about having dental work done? ……………………………………………….. Yes No

Would you like Nitrous Oxide (Laughing gas) ? ………………………………………………………………… Yes No

Do you smoke or use any tobacco products? ……………………………………………………………….. Yes No

Women: Do you take birth control pills _____ Are you pregnant _____ Are you nursing _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the doctor at the next appointment without fail. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my endodontist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I understand that treatment is no guarantee of success and that complications which may result in tooth loss or necessitate further treatment may occur. I also understand that I am to return to my dentist for permanent restoration of the treated tooth.

X______________________________________________________________________________________

Signature of Patient or parent /guardian if a minor Date

## FINANCIAL POLICY

We recognize the need for a clear understanding of your financial obligations for the treatment you receive. In order to create a better understanding between patients and our office, we have adopted the following policy. If you have any questions about this policy, feel free to ask our staff for clarification.

**Dental Insurance**

We accept all dental insurance plans and will gladly file your claim for you. This is a service provided for free by Bowling Green Endodontics. The estimated co-payment is due on the date of service. Once your insurance claim has been received, however, you will be responsible for any unpaid balance that your dental insurance company does not pay to cover the cost of your treatment._ If your insurance claim pays more than our estimate, a check for the full amount of the credit balance will be returned to you. For your convenience, we accept cash, check, Visa, MasterCard, Discover, and CareCredit.

**Returned Checks**

Returned checks will incur a $25.00 service fee.

**Collection**

The undersigned understands and agrees that the account balance is due, in full, upon receipt of the statement. If the account is not paid in full within 90 days from the date of service, the undersigned agrees to be liable for all costs of collection, including attorney's fees and court costs.

**Missed Appointment Fee**

As a courtesy to our office, we ask our patients to give 24 hour notice if the scheduled appointment must be broken. However, if no notice is given, a missed appointment fee of $50.00 will be charged to the patient's billing statement.

X______________________________________________________________________

Signature of Patient, Parent, or Guardian Date

**Root Canal Therapy Consent**

We are concerned not only about your dental health and root canal treatment needs, but also about your right as a patient to make the treatment decision that you feel is best for you. Our aim is a mutual sharing and understanding of information. We feel it is important to advise you of the reasonably foreseeable risks of root canal therapy. The following is important information you need to have in making your decision about treatment:

1. There are alternatives to root canal therapy. They include no treatment at all, extraction with no replacement, or extraction followed by a bridge, partial denture, or implant to fill the space created after the extraction.
2. We make special efforts to preserve the crowns of teeth we treat, but despite our best efforts, occasionally porcelain crowns may be destroyed during treatment.
3. Fractures are one of the main reasons root canals fail. Unfortunately, some cracks extend from the crown down into the root are invisible or hard to detect. Whether the fracture occurs before or after the root canal, it may require extraction (removal) of the tooth.
4. Root canal therapy is designed to save a tooth that may otherwise require extraction (removal). Root canal therapy has a very high success rate but it cannot be guaranteed. Even after root canal therapy, approximately 5% of treated teeth may eventually require extraction (removal).
5. Root canal therapy success is highly dependent upon returning to your dentist after this appointment in a timely fashion for a proper permanent restoration. At the completion of root canal therapy, a temporary restoration will be placed which needs be replaced with a permanent filling or crown by your dentist within 6 weeks. Failure to do so can result in extraction (removal) of the treated tooth.
6. We invite and welcome all of your questions regarding our work with you.

X______________________________________________________________

Signature of patient, parent or guardian Date

______________________________________________________________

Signature of Witness Date