CONFIDENTIAL HEALTH HISTORY: Circle any of the following which you have had or have at present:

AIDS / HIV	Congenital Heart Valve	Hemophilia	Reflux Disease
Allergies or Hives	Cortisone Medicine	Hepatitis A, B, C, D	Rheumatic Fever
Anemia	Diabetes	High Blood Pressure	Sinus Trouble
Arthritis	Drug Addiction	Kidney Trouble	Stomach Ulcers
Artificial Joint	Epilepsy or Seizures	Latex Allergy	Stroke
Asthma	Excessive/Prolonged Bleeding	Liver Disease	Thyroid Disease
Blood Transfusion	Heart Murmur	Lung Disease	Tuberculosis (TB)
Chemotherapy	Heart pacemaker	Mitral Valve Prolapse	Venereal Disease
Claustrophobia	Heart Trouble	Pain in Jaw Joints/TMJ	X-ray/Cobalt Treatment
			Yellow Jaundice

ARE YOU HAVING TOOTH PAIN OR DISCOMFORT AT THIS TIME? ..... YES NO

ARE YOU ALLERGIC TO OR MADE SICK BY ANY MEDICATION? (Please list) _____ YES NO

HAVE YOU EVER HAD A REACTION TO DENTAL ANESTHETIC, INJECTION? ..... YES NO

DO YOU HAVE ANY DISEASE OR CONDITION NOT LISTED? IF YES, PLEASE EXPLAIN _____

IF FEMALE, ARE YOU PREGNANT, BREAST-FEEDING OR TAKING ORAL CONTRACEPTIVES? ..... YES NO

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING (including aspirin, birth control pills, ect.) _____

YOUR FAMILY PHYSICIAN NAME AND PHONE NUMBER: _____

In case of emergency please contact: _____

I have answered these questions to the best of my knowledge X _____
Patient's Signature (Parent if under 21) (date)

X _____
Print Name

NORTHSIDE ENDODONTICS, INC.

CONFIDENTIAL **PERSONAL INFORMATION FORM** **PLEASE PRINT**

Patient's Name _____ d.o.b. _____ SS#_____ M F

Responsible Party (if not patient)_____ Relationship to Patient:_____

Address of Patient or Responsible Party: (Street) _____

(City) _____(State)_____ (zip) _____

Phone (cell) _____ (home) _____ (work)_____Email: _____

Communication Preference: ❑Cell ❑Home Phone ❑ Email

Name of DENTIST or person that referred you to our office: _____

DENTAL INSURANCE: Carrier Name _____ Please present card to be copied

PRIMARY: Subscriber: _____ SS# _____dob _____

Employer: _____ Group Number _____

Employer Address: _____

SECONDARY: Carrier Name_____ Please present card to be copied

Subscriber: _____ SS# _____dob _____

Employer: _____ Group Number _____

Employer Address: _____

I hereby authorize payment directly to Northside Endodontics of the group insurance benefits otherwise payable to me. I authorize release of any information relating to submitting claims to my insurance carrier.

Patient/Responsible Party Signature_____ date:_____

****

I understand that I am responsible for all costs of dental treatment and that if payment is not made when due, either after insurance pays or per prior payment arrangements made, the account may be turned over for collection. I will also be responsible for any and all costs associated with the collection procedure, including but not limited to billing costs, collection fees, lawyer's fees, and court costs.

Patient/Responsible Party Signature_____ date:_____

****

I acknowledge that I have read and was offered or given a copy of the Northside Endodontics Notice of Privacy Practices.

Please list any persons who we may speak to regarding your account, appointments or dental treatment:

_____ _____

Patient/Responsible Party Signature_____ date:_____

You may refuse to sign the acknowledgement statement for the Northside Endodontics Notice of Privacy Practices.

Reason:_____