REGISTRATION FORM FOR ROOT CANAL SPECIALISTS, P.C.

PATIENT INFORMATION (PLEASE PRINT)

First Name:	Middle:	Last:	Birth date:	Social Security no.:

Street address:	Apt:	City:	State:	ZIP Code:	Home phone #:

Driver's License:	Cell #:

Employer:

Email:	Employer phone #:

Referred by : DDS Name:

IF PATIENT IS A MINOR

Name:	Birth date:	Address (if different):	Phone #:

Employer:	Employer address:	Employer phone #:

Driver's License: Social Security #:

Dental insurance? ❑ Yes ❑ No Relationship to Patient:

DENTAL INSURANCE INFORMATION (PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)

Primary Dental Insurance Name:

❑ hourly
❑ Salary
❑ Retired

Subscriber's name: Employer:

Subscriber's S.S. / ID #:	Birth date:	Group #:	Policy/Contract #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Dental Insurance Name:

❑ hourly
❑ Salary
❑ Retired

Subscriber's name: Employer:

Subscriber's S.S. / ID #:	Birth date:	Group #:	Policy/Contract #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.:	Cell phone no.:
		( )	( )

TREATMENT AUTHORIZATION

I have reviewed the following treatment plan. I authorize Root Canal Specialists to release any information relative to this claim to my insurance carrier. In addition, I hereby authorize payment of insurance benefits for myself and/or my dependents, otherwise payable to me, to Root Canal Specialists. I agree to be responsible for any charges not paid by my dental plan.

X_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

--OVER--

PATIENT'S MEDICAL HISTORY

Date_____

YES	NO	
☐	☐	Are you in good health?
☐	☐	Are you under a physicians care? If yes, why? _____
☐	☐	Do you take aspirin or blood thinners daily? If yes, what? _____
☐	☐	Have you ever had radiation and/or chemotherapy treatment (cancer)? When? What type? _____
		_____
☐	☐	Do you pre-medicate with antibiotics for all dental procedures? If yes, why? _____
☐	☐	Do you currently take Bisphosphonates (e.g. Fosamax, Actonel, Etc.)?
☐	☐	Are you taking oral contraceptives?
☐	☐	Are you pregnant? What month? _____
☐	☐	Are you taking any medications now? **Please list all below**:

_____

_____

Circle any of the following which you are allergic, or that you have had an unusual reaction to:

Penicillin	Aspirin	Latex
Sulfa	Codeine	Nitrous Oxide
Cleocin	Valium	Decadron – (Deximethisone)
Amoxicillin	Epinephrine – (Adrenaline)	Local Anesthetic – (Novocaine)

If not listed above, please note:_____

Circle any of the following, which you have or have had.

Heart Disease	Diabetes	Epilepsy	Kidney Trouble
Heart Murmur	Stroke	Glaucoma	Fainting Spells
Endocarditis	Asthma	Tuberculosis	Psychiatric Treatment
High Blood Pressure	Hepatitis	HIV - AIDS	Blood Disorders
Congenital Heart Disease	Anemia	Ulcers	Respiratory Lung Disease
Rheumatic Fever	Cancer	TMJ	Chemical Dependency

Is there anything else about your health we should know?

_____

_____

PERMISSION FOR EXAMINATION

I, herby certify that all of the above information is correct.

I, the undersigned, consent to the performance of whatever examination and/or endodontic procedure that may be deemed necessary or advisable in the opinion of the doctors. I understand the doctor will examine me and proceed with treatment only after they explain what they will do. I have the right to refuse treatment after this explanation. **I also understand that I am to return to my family dentist for permanent fillings of the treated teeth.**

X_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

PAYMENT EXPLANATION

I, the undersigned, understand that the responsibility for payment for dental services provided by Root Canal Specialists, P.C. for me or my dependents is mine and is due and payable at the time services are rendered, unless prior written financial arrangements have been made.

In addition, I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance. I also understand that, should I default on any payments, Root Canal Specialists, P.C., shall have the right, without notice, to declare the entire unpaid invoiced amount immediately due and payable.

If payment is not made on the date the dental services are provided, I agree to pay interest on the unpaid balance of my account at a rate of seven (7%) percent annually, until payment is made in full. In the event the interest rate provided above (including any amounts which shall be deemed interest under Michigan usury laws) should at any time exceed the legal maximum interest rate allowable under Michigan law, then the interest rate shall be adjusted to the legal maximum amount allowed under Michigan law. Additionally, I agree to pay all costs and expenses of collection incurred by Root Canal Specialists, P.C. in collecting the same, including reasonable attorney's fees and any fees charged by any collection company. I also agree to pay Root Canal Specialists, P.C. a service fee of Thirty-Five and 00/100 ($35.00) Dollars per check for each check which is not honored by the bank for immediate payment upon presentation.

X_____ _____

PATIENT/GUARDIAN SIGNATURE **Date**

ROOT CANAL SPECIALISTS PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(**Please Print**) I, _____, have received a copy of the **Notice of Privacy Practices** of this office.

_____ _____

Signature Date

Please PRINT the names of family member(s) who we may disclose your health information to:

_____ _____

_____ _____

Please Note: It is your right to refuse to sign this acknowledgement

We attempted to obtain written acknowledgement of receipt of our **Notice of Privacy Practices,** but acknowledgement could not be obtained because:

☐ Individual refused to sign. Date: _____

☐ Communication barriers prohibited us from obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other (Please Specify)

_____

_____

_____