We want to extend our personal greetings and a very warm welcome to our practice. Dr. Steven Elkhal and his staff are committed to doing everything possible to provide you with excellent care and also to make your visit to our office as pleasant and as comfortable as possible. Please take a moment to answer the following questions.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Subscriber date of birth & ID# or SSN

_____

MEDICAL HISTORY

Please take a moment to let us know about your medical and dental history so we may serve you more effectively for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

Your Primary Care Physician's name and phone number:

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Are you currently taking any prescription or non-prescription medications?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you have any other conditions, diseases, etc..., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

Please list all medications that you are currently taking:

Are you allergic to any of the following?

- [ ] Aspirin
- [ ] Penicillin
- [ ] Codeine
- [ ] Acrylic
- [ ] Metal
- [ ] Latex
- [ ] Local Anesthetics
- [ ] Other

Please indicate if you have been diagnosed with the following:

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Allergies
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

- [ ] To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment.

OFFICE POLICY & STATEMENT OF PRIVACY PRACTICES

APPOINTMENTS

When scheduling your appointments, we are making a commitment to you. Please remember that we have reserved a special time for you. If you need to reschedule your appointment, we ask a minimum of 24 hours notice. Failed appointments and canceled appointments without 24 hours notice are subject to a $25.00 fee.

FINANCIAL

Patient portion is due at the time of service. We accept the following methods of payments for your convenience.

*Cash *Debit *Visa/MC *Amex/Discover *CareCredit

INSURANCE

We will bill your insurance as a courtesy to you and will allow your insurace company up to 90 days to pay your claim. If any amounts are denied or not covered, the balance owing is your responsibility. Your estimated patient portion for services is based upon information provided by your insurance company, and is expected on the day treatment is rendered. Our treatment plans are an estimate only and will be valid for 90 days. After that, any new findings may need to be estimated and diagnosed for proper treatment at which time any current fees may apply.

UNDERSTANDING AND AGREEMENT

I understand and agree to the terms of the agreement above, including paying the difference between quoted and actual benefits. I will pay my estimated portion of the charges at each date of service according to to financial estimate and will notify Endodontics Limited if a change has occured in my benefits. Finally, I agree to pay any unpaid balance remaining after insurance payment and/or remaining 90 days from the date I received the service. I also understand that Endodontics Limited reversus the right to apply a late payment charge of $10 for any balance over 30 days old.

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have recived a copy of the statement of privacy practices. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties to this office that respect to my protected health information.

ADDITIONAL DISCLOSURE AUTHORITY

I authorize the release of information concerning my (or my child's) healthcare to this additional person or organization: