CHAE ENDODONTICS

Patient Medical History

Name (Last, First)**:** _____ **Date of Birth** ___/___/_____ **Age:** _____

Street address: _____ **City:** _____ **Zip:** _____

Phone #: (___**)** ____**-**_____ **Email Address:** _____

Current Dentist: _____ **Office Phone #: (**___**)** ____**-**_____

Emergency Contact: In the event of an emergency, is there someone we should contact?

Name: _____ **Phone #: (**___**)** ____**-**_____ **Relation:** _____

Have you ever had any of the following?:

Y I N Abnormal Bleeding
Y I N Anemia
Y I N Asthma
Y I N Hepatitis
Y I N Diabetes
Y I N Difficulty Breathing
Y I N Drug/Alcohol Abuse
Y I N Emphysema
Y I N Epilepsy/Seizures
Y I N Fainting Spells
Y I N Glaucoma
Y I N High/Low Blood Pressure
Y I N Heart Disease / Irregular pulse
Y I N Heart Murmur / Mitral Valve Prolapse
Y I N Heart Surgery / Pacemaker
Y I N Herpes
Y I N HIV/AIDS
Y I N Cancer / Chemotherapy / Radiation
Y I N Kidney Problems
Y I N Psychiatric Problems
Y I N Severe Headaches
Y I N Sinus Problems
Y I N Tuberculosis
Y I N Osteoporosis

Are you allergic to any of the following?:

Y I N Penicillin
Y I N Erythromycin
Y I N Tetracycline
Y I N Dental Anesthesia
Y I N Aspirin
Y I N Latex
Y I N Codeine

Other: _____

Physician: _____ Tel #: (____) ____-_____ Date of last visit:_____

Current physical health status is: Good I Fair I Poor

Are you currently under the care of a Physician?: Yes I No
If yes; Please explain: _____

Are you taking any prescription or over the counter medications? Yes I No

Please list medications: _____

Do you have any medical conditions which warrants antibiotics prior to treatment? Yes I No

Please list specific medical condition(s): _____

For Women Only
Are you pregnant Yes I No **If yes,** how many weeks? _____

Are you nursing? Yes I No Are you taking birth control medications? Yes I No

Dental Insurance Information:

Primary

Subscriber Name: _____

Subscriber ID: _____

Subscriber D.O.B. _____

Subscriber Employer: _____

Insurance Carrier Name: _____

Insurance Group #: _____

Insurance Address: _____

Insurance Phone #: _____

Secondary

Subscriber Name: _____

Subscriber ID: _____

Subscriber D.O.B. _____

Subscriber Employer: _____

Insurance Carrier Name: _____

Insurance Group #: _____

Insurance Address: _____

Insurance Phone #: _____

I understand it is my responsibility to update this office with any changes to patient records including information, medical history and insurance. By signing below I acknowledge that this information is true to the best of my knowledge.

Signature: _____ Date: _____

Update Signature: _____ Date: _____

CHAE ENDODONTICS

Office Financial Policy

The doctor and entire staff appreciate you selecting our office for your Endodontic treatment. Our goal is to provide you with the best possible care and to keep the investment in your dental health to a minimum. Our financial coordinator will discuss the fees for this treatment with you. For our patients' convenience, we accept personal check, cash, Mastercard, Visa, and Care Credit.

For our non-insured patients, we will provide a financial agreement indicating your appointments and amounts due. Your fee will be due upon completion of treatment.

For our insured patients, we will submit a claim form as a courtesy to you with the understanding that total payment of the dental service is the responsibility of the patient, and not the insurance company. If you direct the insurance benefits to our office, we will give you credit for this approximated amount. However, we do ask that your estimated share be paid at completion of treatment. Upon receipt of the insurance payment, we will reconcile the account and bill or refund any differences. Our experienced team will help in every way possible with filing claims and handling any insurance issues.

Our fee does not include the cost of the permanent restoration which will be done by your original existing dentist after your Endodontic treatment is completed.

No question is too small to ask whether it pertains to your treatment, insurance or payments.

Please do not hesitate to ask if we can be of assistance.

Thank You!

Signature (patient/guardian) _____ **Date** _____

CHAE ENDODONTICS

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protecting your health information

Chae Endodontics is committed to protecting the privacy and the confidentiality of your information. We recognize that you depend on us to safeguard your personal information and uphold your privacy rights. This document, which is based on state and federal law, describes our commitment to preserve the privacy and confidentiality of your health information. This notice explains our privacy practice, our legal requirements and your rights regarding your protected health information (PHI).

Our Privacy Practice

This notice protects the rights of both current and former members of our practice. It explains how we use your information and when we may share that information with others. It provides you with your rights with respect to your health and/or dental information and how you may exercise those rights. By law, we are required to send you this notice so that you are aware of how we maintain the privacy of your information.

Employees of Chae Endodontics are required to comply with our company policies and procedures to protect the privacy and confidentiality of your health and/or dental information. Violations identified or reported to Chae Endodontics are reviewed, and disciplinary and/or corrective actions are taken when appropriate. Access to information by our employees is limited to a business "need to know" basis. For example, employees of Chae Endodontics need specific information to make benefit determinations, process claims, perform internal assessments and provide certain customer service functions.

Chae Endodontics uses physical, electronic, and process safeguards restrict access to your information. These safeguards include secured office facilities, locked filing cabinets, and controlled computer network systems.

How We May Use or Share your information:

For Treatment – Dental information may be shared with your dentist for proper care

For Payment – Your information may be used when submitting dental claims to your Dental insurance group.

CHAE ENDODONTICS

Acknowledgement of Privacy Practice

I have read and understand the privacy practice.

I have also been offered a copy of this privacy practice if I wish to take it with me. I acknowledge that I can always request a copy of this privacy practice from the office at any time.

Patient/Guardian: _____

Signature: _____ Date: _____