2981 Voyager Drive
Green Bay, WI 54311

GREEN BAY
ENDODONTICS

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PATIENT INFORMATION AND HISTORY

Name: _____ Age _____ Birthdate _____
Last First Middle Initial ☐ Male ☐ Female

Address _____
Number Street City State Zip Code

Social Security _____ Email _____ Tel # ( ) _____

Occupation _____ Employer _____ Bus. Tel # ( ) _____

Referred By _____ Dentist _____ Physician _____

SPOUSE, PARENT, OR OTHER GUARANTOR INFORMATION IF DIFFERENT THAN ABOVE

Who will be responsible for your account? ☐ Spouse ☐ Father ☐ Mother ☐ Other

Name _____ Birthdate _____ SS# _____

Address _____ Tel # ( ) _____

Employer _____ SS# _____ Bus. Tel # ( ) _____

PRIMARY DENTAL INSURANCE:

Policy Holder _____ SS# _____ Birthdate _____

Dental Company _____ Group # _____

Member ID # _____

SECONDARY DENTAL INSURANCE:

Policy Holder _____ SS# _____ Birthdate _____

Dental Company _____ Group # _____

Member ID # _____

Please see back side for additional questions ☛

Weight_____Height_____

1. Are you under any medical treatment now?..... ☐ Yes ☐ No
2. Are you taking any drugs or any medication now? ☐ Yes ☐ No If Yes _____

_____

3. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphophonates? ☐ Yes ☐ No If Yes _____
4. Have you had any major operations recently? ☐ Yes ☐ No If Yes _____
5. Have you ever had any joint or valve replacements in the past 2 years? ..... ☐ Yes ☐ No
6. Have you or your relatives had a bad reaction to anesthesia?..... ☐ Yes ☐ No
7. Have you ever had an adverse reaction to any of the following? ☐ Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Local Anesthetics
   ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ No ☐ Other _____

_____

8. Have you ever had a serious accident involving head or neck injuries? ☐ Yes ☐ No If Yes _____
9. Please check any of the following that apply to you:

☐ AIDS/HIV Positive	☐ Cold Sores/Canker Sores	☐ Heart Pacemaker	☐ Lung Disease	☐ Sickle Cell Disease
☐ Alzheimer's Disease	☐ Congenital Heart Disorder	☐ Hemophilia	☐ Mitral Valve Prolapse	☐ Sinus Trouble
☐ Anaphylaxis	☐ Cortisone Medication	☐ Hepatitis A or E	☐ Osteoporosis	☐ Spina Bifida
☐ Anemia	☐ Diabetes	☐ Hepatitis B or C	☐ Pain in Jaw Joints/TMJ	☐ Stomach/Intestinal Disease
☐ Angina/Chest Pain	☐ Drug Addiction	☐ High Blood Pressure	☐ Parathyroid Disease	☐ Stroke
☐ Arthritis	☐ Emphysema	☐ High Cholesterol	☐ Psychiatric Disorder	☐ Swelling of Limbs
☐ Artificial Heart Valve	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Radiation Treatments	☐ Thyroid Disease
☐ Artificial Joint	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Recent Weight Loss	☐ Tonsillitis
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Renal Dialysis	☐ Tuberculosis
☐ Breathing Problems	☐ Frequent Headaches	☐ Kidney Problems	☐ Rheumatic Fever	☐ Tumors or Growths
☐ Bruise Easily	☐ Glaucoma	☐ Leukemia	☐ Rheumatism	☐ Ulcers
☐ Cancer	☐ Heart Attack/Failure	☐ Liver Disease	☐ Scarlet Fever	☐ Venereal Diseases
☐ Chemotherapy	☐ Heart Murmur	☐ Low Blood Pressure	☐ Shingles	

10. Do you/did you abuse alcohol or drugs?..... ☐ Yes ☐ No
11. Do you have a severe gag reflex? ..... ☐ Yes ☐ No
12. Have you had any abnormal oral bleeding? ..... ☐ Yes ☐ No
13. Do you smoke or use tobacco?..... ☐ Yes ☐ No Quit:_____
14. (Female) Are you or could you be pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Oral Contraceptive? ☐ Yes ☐ No
15. Have you ever had any serious illness not listed? ☐ Yes ☐ No If Yes _____

Authorize

Privacy Practice Notice

I hereby acknowledge that a copy of Green Bay Endodontic's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask questions I may have regarding this Notice.

Patient/Parent (Guardian) Initials: _____

Authorization to Release All information to:_____Relationship: _____

I understand that by initialing below I am confirming the use and disclosure of my protected health information to the authorized person(s) listed above. Authorization is good until I choose to revoke it.

Patient/Parent (Guardian) Initials: _____ ☐ **DECLINE RELEASE OF MY INFORMATION**

I hereby confirm that the above facts are true to the best of my knowledge. I will not hold my doctor or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature_____Date _____

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RESPONSIBILITY FOR PAYMENT

PATIENT NAME: _____

I agree to be and am fully responsible for total payment of services performed including any amounts not covered by any dental insurance, I may have.

I understand that the parent who requests treatment and/or presents a minor child for treatment is responsible for all fees for services rendered. In case of divorce, any arrangements made through a divorce agreement are strictly between the parents and do not involve the clinic.

I understand that clinic bills are due at the time of service regardless of any insurance coverage. Insurance is designed to reimburse the policy-holder and is a contract between the policyholder and the insurance company. The clinic has an insurance department and will do all it can to help collect legitimate claims. In the event the insurance company is slow to pay; reduces payment because in their estimation the charges are over usual and customary; or for some reason disallows the claim, I understand payment of the account is my responsibility.

(IF INSURED) I authorize the release of information including records and x-rays requested by my insurance company for the purpose of determining pre-treatment estimates, precertification or payment of insurance benefits. A copy of this authorization shall be as valid as the original.

_____ _____

Signature of Patient or Parent/Guardian Requesting Care Date

If guardian responsible for payment is other than parent:

Name: _____ Relationship: _____

Address: _____ Phone:( ) _____