PATIENT INFORMATION

NAME: ____
FIRST MIDDLE INITIAL LAST

SSN #:__________________ **BIRTHDATE**:__________________ **SEX:** Male Female

MARITAL STATUS: Single Married Domestic Partnership

HOME ADDRESS:____
STREET CITY STATE ZIP

HOME PHONE:____________________ **CELL:**____________________ **WORK :**____________________

EMAIL: ____________________@__________.________

IF PATIENT IS A MINOR….

PARENT/GUARDIAN'S NAME: ____________________

PARENT/GUARDIAN'S BIRTHDATE: _______________ **PARENT/GUARDIAN'S SSN #:** ________________

SPOUSE OR PARTNER INFORMATION

NAME:_______________________ **DATE OF BIRTH:** __________________ **PHONE:** __________________

CONTACT IN CASE OF EMERGENCY IF DIFFERENT FROM SPOUSE OR PARTNER

NAME: _______________________**PHONE:**___________________ **ALT. PHONE:** ____________________

INSURANCE INFORMATION

PRIMARY INSURANCE: _____________________ **POLICY #**:_________________ **GROUP**: __________

INSURED'S NAME: ______________________________________

RELATION TO PATIENT: SELF SPOUSE PARENT

INSURED'S SSN#: _____________________ **INSURED'S DATE OF BIRTH:** _________________

INSURED'S EMPLOYER:________________________ **INSURED'S OCCUPATION**:______________________

SECONDARY INSURANCE: ___________________ **POLICY #**:___________________ **GROUP:** ________

INSURED'S NAME: ______________________________________

RELATION TO PATIENT: SELF SPOUSE PARENT

INSURED'S SSN#: _____________________ **INSURED'S DATE OF BIRTH:** _________________

INSURED'S EMPLOYER:________________________ **INSURED'S OCCUPATION**:______________________

MEDICAL HISTORY

NAME: ____
FIRST MIDDLE INITIAL LAST

1. Are you having tooth pain or discomfort at this time? Yes No
2. Have you been under the care of a medical doctor during the past two years? Yes No
3. If you have been under the care of a doctor, what condition(s) was treated or is currently being treated?
   ____
   a) Physician's Name: ______________________ b) Physician's Phone #: ______________________
4. If you are taking any medications, please list them: ______________________
5. If you are taking Fosamax or any other medication for bone conditions, please list them: ______________________
6. If you are sensitive or allergic to any medications, please list them: ______________________
7. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? Yes No
8. Have you lost or gained more than 10 pounds in the past year? Yes No
9. Do you ever wake up from sleep and feel short of breath? Yes No
10. Have you ever had any history of TMJ (jaw joint) disorders or pain? Yes No

Please write Y for yes or N for no for any of the following you have had or presently have:

Heart Failure		Artificial Joint (hip, knee)		Allergic to Latex		Stroke	
Heart Disease or Attack		Kidney Trouble		Hepatitis B (serum)		Ulcers	
Angina Pectoris		Diabetes		Venereal Disease		Hepatitis A (infectious)	
Congenital Heart Disease		Thyroid Problems		AIDS		Hemophilia	
Heart Murmur		Sinus Trouble		HIV Positive		Drug Addiction	
High Blood Pressure		Cancer		Cold Sores/Fever Blister		Chemotherapy	
Arteriosclerosis		Emphysema		Blood Transfusion		Allergy to Shellfish	
Mitral Valve Prolapse		Chronic Cough		Anemia		Cortisone Medicine	
Artificial Heart Valve		Tuberculosis		Sickle Cell Anemia		Radiation Therapy	
Heart Pacemaker		Asthma		Bruise Easily		Rheumatism	
Heart Surgery		Arthritis		Liver Disease		Fainting or Dizzy Spells	
Rheumatic Fever		Allergies or Hives		Yellow Jaundice		Allergy to Iodine	
TMJ		Epilepsy or Seizures		Developmentally Disabled		Allergy to Bleach	
SARS		Pneumonia		Parvovirus B19		Mumps	
Pertussis or Whooping Cough		Meningitis		Diphtheria		Haemophilus Influ-enzae Type b (H1B)	
Group A Streptococcus (GAS)		Pharyngitis		Rubella		Viral Hemorrhagic Fevers (FHFs) Ebola	
Mycoplasmal Pneumonia		Meningococcal disease sepsis, pneumonia		Pneumonic plague/ Yersinia Pestis		Adeno Virus	

11. Please list any other condition you may have: ______________________

For Women Only

12. Are you pregnant? Yes No 13. Are you nursing? Yes No 14. Are you taking birth control pills? Yes No

I have completed this medical history form and have answered the questions truthfully and to the best of my knowledge.I understand that it is my responsibility to advise the Doctor's office of any changes in my personal information or medical history.

Patient Signature: ______________________ Date: ______________________

CONSENT FOR INITIAL EXAMINATION

I hereby give my consent to Dr. Zoufan and his assistants to perform an initial examination prior to any definitive treatment. This consent is for evaluation only and no invasive treatment will be performed prior to discussion of proposed treatment with the doctor and trained staff.

This initial evaluation consists of, but is not limited to: examination of diagnostic radiographs, pulp vitality testing, localized periodontal examination, and definitive treatment planning. I understand that in some instances, a local anesthetic (numbing) may be needed for diagnostic purposes.

I understand that diagnostic radiographs may be needed at the doctor's discretion. I also understand that the doctor may require consultation with other dental and medical professionals prior to the initiation of any treatment. I authorize Zoufan Endodontics to obtain any necessary medical history or clearance for treatment from my physician(s) and to send any necessary dental records either to those actively participating in my care or to me personally.

I understand there is a fee for initial consultation. As a courtesy, Zoufan Endodontics will submit an insurance claim on my behalf; however, I am ultimately responsible for the balance.

Patient's Signature: ________________________________ Date: _____________

ACKNOWLEDGMENTS

I have received and reviewed Zoufan Endodontic's **FINANCIAL POLICY** (blue sheet) and agree to the terms stated. I understand that I am fully responsible for payment of treatment provided by this office. Further, I authorize Zoufan Endodontics to obtain and verify my insurance benefits and eligibility with my dentist(s) or dental insurance carrier, as well as to file claims to my insurance carrier on my behalf.

I have received and reviewed Zoufan Endodontic's **NOTICE OF PRIVACY PRACTICES** (bright orange sheet).

Patient's Signature: ________________________________ Date: _____________