Advanced Endodontics & Microsurgery of Stamford, PC - 8/5/2020

Patient Information

Contact

Address			
City	State	Zip	Gender
Primary Phone	Cell Phone	Date of Birth	Email
How did you hear about our office?			
Reason for consultation?			

Insurance Information

Responsible Party First name	Responsible Party Last Name	Address	City
State	Zip	Primary Phone	CellPhone
Date of Birth		SSN#	

Insurance (if applicable)

Insurance Company	Phone	Group #	Subscriber/Member ID #
Insurance Address		Employer Name	

Secondary Insurance (if applicable)

Secondary Insurance			
Insurance Company	Phone	Group #	Subscriber/Member ID #
Insurance Address		Employer Name	

Medical Information

Medical History

Acid Reflux	AIDS/HIV	Anemia	Arthritis
Asthma	Bone Disorders	Cancer	Chest Pain
Chronic Neck Pain	Cold Sores/Herpes	Diabetes	Endocrine Problems
Emotional Disorders	Epilepsy	Headaches	Heart Condition
Hepatitis	Ear Pain	Immune Problems	Kidney Problems
Low Blood Pressure	Muscular Disorders	Nervous Disorders	Organ Transplant
Osteoporosis	Prolonged Bleeding	Rheumatic Fever	Seizures
Sinus Problems	Tuberculosis	Joint Replacement	

Dental History

Clicking of Jaw	Jaw Pain	Painful Chewing	Periodontal Problems
TMJ Problems	Do your gums bleed when you brush?	Is the patient seeing any other dental specialists?	Any dental restorations needing to be completed?
Have there ever been any injuries to the face, mouth or chin?	Do you have any pain or soreness around your face, neck or back?	Is any part of your mouth sensitive to temperature or pressure?	Is the patient currently pregnant?
Currently taking any medications?	Are antibiotics necessary prior to treatment?	Allergies?	Any diseases or problems not mentioned above?

Financial Information & HIPAA Acknowledgement

Patients will be responsible for all legal fees and collection costs, as well as payments and any balance that insurance doesn't pay.

Payment is due at time of service.

Please select your payment method.

Cash	Check	Card

If you selected Card pleaese fill out the information below

Card Type:

MasterCard	VISA	Discover	Other

Cardholder Name (as shown on card) :	Card Number	Expiration Date (mm/yy)	Cardholder ZIP Code (from credit card billing address) :

Card Validation Code

Your card information is kept on file for outstanding account balances

Signature

Date

Patient Acknowledgement of Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent of Use of Health Information

The undersigned does hereby acknowledge that they have received a copy of this office's Notice of Privacy Practices pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance leaflet is available upon request. The undersigned does hereby consent to the use of their health information in a manner consistent with the Notice of Privacy Practices pursuant to HIPAA, the HIPAA Compliance leaflet, State law and Federal law.

If the undersigned is a parent or guardian of the patient, they do acknowledge and consent to the above paragraph on behalf of the patient.

Date	Patient Name

Patient/Parent/Guardian Signature

For more information, contact: The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 (877) 696-6775 (toll-free)