# ENDODONTIC SPECIALISTS

12520 Prosperity Drive, Suite 230.
Silver Spring, MD 20904
301-593-4400

Young S. Lee, D.M.D
John Coviello, D.D.S
Renie Gross, D.D.S

## Patient Information

Referred By: ____________________ Today's Date: ____________

Patient Last Name: __________________________________ First: _________________________________ MI: ______________

Address [street, city, state, zip code]: __________________________________________________________________

Phone # (Home): _____________________________ (work) _______________________ ext __________ (cell) _____________________

Sex: □Male □ Female Marital Status: □ Single □ Married □ Widow □ Divorced □ Child School: ______________________________

Social Security #: _______________________ Date of Birth: _________________________________ Age: ___________________

Employer Name: _________________________________________ Occupation: _________________________________ □FT □PT

Email: ____________________________________ Emergency Contact: _________________________ Relationship: _______________

Phone #:_____________________________________

## Responsible Party (Parent/Guardian)

Person Responsible for Account Full Name: _______________________________________________________________

Date of Birth: _______________ Social Security #: ____________________

Phone #: ____________________ Address (If different from above): _____________________________________________

## Insurance Information

Subscribers Full Name [Last, First, MI]: ___________________________________________________________________

Insurance Company Name: _______________________________________ Insurance Phone #: ___________________________________

Insurance Address: ______________________________________________________________________________________

Member ID #: ______________________________ Group #: ________________________ Date of birth: ___________________________

Patient's Relationship to insured: □ Self □ Spouse □ Child □ Other: ______________________________

## Health Information Assignment & Release

Endodontic Specialists may disclose my health care information to the referring dentist office and/or above named insurance company, the latter for determining insurance benefits and obtaining payment for services. I understand that I am financially responsible for all charges whether or not paid by insurance. I assign all applicable insurance benefits to be paid directly to Endodontic Specialists for services rendered. I authorize the use of my signature on all insurance submissions. I hereby authorize Endodontic Specialists and their doctor(s) to perform a focused area examination and to take necessary radiographs. I understand that an $85.00 fee will be charged for broken treatment appointments not cancelled or rescheduled with at least 24 hour notice. I read and understood the above statements.

X_____________________________________ _________________________________
Signature of Patient/Responsible Party Printed Name

Date: ________________________ Relationship to patient: __________________________________

## Health History

Name of Physician: ____________________________________________Date of last visit: ______________________

Are you currently taking prescription medications: □ No □ Yes, List Medications: ____________________________________

______________________________________________________________________________________________

Are you allergic to any medications, anesthetics, or latex? □ **No** □ **Yes,** explain: ____________________________________

Do you have any health condition, such as prosthetic heart valve, artificial joints or rheumatic fever, that require antibiotic pre-medication prior to routine dental procedures? □ **No** □ **Yes**

Please check Yes or No to indicate if you have ever had any of the following. If yes, please explain below.

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Artificial Joints | ☐ | ☐ | Prosthetic Heart Valve | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Epilepsy | ☐ | ☐ | Pacemaker | ☐ | ☐ |
| AIDS/HIV | ☐ | ☐ | Heart Disease | ☐ | ☐ | Respiratory Problems | ☐ | ☐ |
| Asthma | ☐ | ☐ | Dizziness/Fainting | ☐ | ☐ | Mental Disorder | ☐ | ☐ |
| Bleeding Disorders | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Sinus Problems | ☐ | ☐ |
| Cancer/Tumors | ☐ | ☐ | Hepatitis/Jaundice | ☐ | ☐ | Stomach Problems | ☐ | ☐ |
| Chronic Pain | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Liver Disease | ☐ | ☐ | Venereal Disease | ☐ | ☐ |

Women: Are you pregnant? □ No □ Yes, number of weeks: _______________ Are you taking birth control pills? □ No □ Yes

Comments: ____________________________________________________________________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I have any change in my health I will inform the dentist promptly.

**X** ______________________________________________________ ______________________

Signature of patient/parent/guardian/personal representative Date

---

***For Office use only***

Health History Reviewed by: _______________________________________ ______________________

Signature of Dentist Date

Comments: ____________________________________________________________________________________