CHRISTOPHER L. COLEMAN, D.D.S., M.S.
J. BRIAN DUNCAN, D.D.S., M.S.
ENDODONTICS
ENDODONTIC ASSOCIATES OF CLEAR LAKE INC.

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT OR WRITE LEGIBLY

Patient Name: ______________________________

Patient's Social Security Number: ______________________________

If Patient Is A Minor, Parent's Name: ______________________________

Patient's Birthdate: ____________ TDL# ____________

Address: ______________________________

City: ____________ State: ________ Zip: ________

Telephone (Home): ____________ (Office): ____________

(Cell): ____________

Who referred you to our office? ______________________________

DENTAL INSURANCE INFORMATION

Employee Name (Insured): ______________________________

Relationship to Patient: ______________________________

SSN/INS ID of Employee ____________ Birthdate of Employee: ________

Employer: ____________ Policy/Group No. ________

Insurance Co. ____________ Phone No. ________

IF DOUBLE COVERAGE APPLIES:

Employee Name: ______________________________

SSN/INS ID of Employee ____________ Birth Date of Employee: ________

Employer: ____________ Policy/Group No. ________

Secondary Insurance Co. ____________ Phone No. ________

HEALTH HISTORY

Patient's Name ____________________ Date of Birth __________ Date __________

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? .... Y N
2. Has there been any change in your health in the past year? .... Y N
3. Date of last physical exam ____________________
4. Are you now under a physician's care for a particular problem .... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe .... Y N
   ____
   ____
6. Height ________ Weight ________
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? .... Y N
   - B. Congenital Heart Disease? .... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker) ? .... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness .... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? .... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? .... Y N
   - H. Kidney Disease? .... Y N
   - I. Diabetes? .... Y N
   - J. Thyroid Disease (Goiter)? .... Y N
   - K. Arthritis? .... Y N
   - L. Stomach Ulcers or Colitis .... Y N
   - M. Glaucoma? .... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip Knee)? .... Y N
   - O. Radiation (X-ray) treatment for Cancer? .... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? .... Y N
   - Q. Sinus or Nasal problems? .... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? .... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics .... Y N
   - B. Anticoagulants (Blood Thinners)? .... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? .... Y N
   - D. High Blood Pressure medication .... Y N
   - E. Steroids (Cortisone, etc.)? .... Y N
   - F. Tranquilizers .... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? .... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? .... Y N
   - I. Are you taking or have you ever taken Bisphosphonates (Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc)? .... Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: ________
     ____
     ____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocaine, etc.)? .... Y N
   - B. Penicillin or other antibiotics? .... Y N
   - C. Sedatives, Barbiturates? .... Y N
   - D. Aspirin or Ibuprofen? .... Y N
   - E. Codeine or other pain killers? .... Y N
   - F. Latex or Rubber Products? .... Y N
   - G. Other allergies or reactions? Please, list .... Y N
     ____
     ____
10. Do you smoke or chew Tobacco? .... Y N
    How much per day? ____________
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .... Y N
12. Have you had any serious problems associated with any previous dental treatments? .... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? .... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .... Y N
15. Do you wish to talk to the doctor privately about anything? .... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant or is **there any chance** you might be Pregnant .... Y N
    - B. Are you nursing? .... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I will have the opportunity to discuss my Health History with my doctor.

____________ Date ____________________ Signature of Person Completing Health History ____________ Doctor's Initials

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Medical Update: I have read my Health History dated ______________ and confirm that it adequately states past and present conditions.

Date	Exceptions or changes	Patient's Signature	Doctor's Initials

INFORMED CONSENT

I understand Root Canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal therapy has a very high degree of success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had Root Canal therapy may require retreatment, surgery, or even extraction.

I also understand that only treatment related to the root canal is to be performed at this office and any required restoration (filling, inlay, crown, etc.) will be done by my regular dentist.

Complications of treatment include, but are not limited to: perforations of the tooth or root, damage to existing fillings or crowns, the possibility of separation of a portion of an instrument that cannot be removed from within the tooth and the possibility of pain, swelling and infection. The use of prescription drugs during treatment may result in unexpected drug reactions. Local anesthetic injections may cause reactions, such as rapid heart rate and paresthesia (a prolonged numbness).

SIGNED ______________________________ DATE____________

CHRISTOPHER L. COLEMAN, D.D.S., M.S.
J. BRIAN DUNCAN, D.D.S., M.S.

ENDODONTIC ASSOCIATES OF CLEAR LAKE INC.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, ____ have been given the opportunity to review and/or obtain a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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FINANCIAL POLICIES AND INSURANCE ASSIGNMENT AGREEMENT

- We ask that payment be made when services are rendered.
- If you have dental insurance, we will always file the insurance for you. Many times, we can file electronically, which may speed payment.
- If the fee is $100.00 or less, we ask that you pay the fee to us, and we will file the insurance to reimburse you directly.
- For higher fees, when dental insurance is involved, we can accept assignment of the benefits, meaning we ask you to pay only what we estimate to be your co-payment. The insurance company may pay more than we estimate, in which case you will receive a refund from us. The insurance company may pay less than we estimate or deny the whole claim, in which case you will owe us the balance of the bill.
- If this is a COBRA, Medical Insurance or Workman's Comp. claim, please let us know in advance.
- If the fee or co-payment seems to be more than you were prepared to pay, please let us know so we can discuss alternatives and options.

Sincerely,

Dr. Chris L. Coleman   Dr. J. Brian Duncan

How will you be paying for your treatment today?

☐ Check   ☐ Cash   ☐ Credit Card

I have read and understand this agreement and consent to allow the office to submit information regarding my claim to my insurance carrier.

Date: ____________________

Signature: ____