**CONFIDENTIAL** **PERSONAL INFORMATION FORM** **PLEASE PRINT**

Patient's Name _____ d.o.b. _____SS#_____

Responsible Party (if not patient) _____ Relationship to Patient _____

Address of Patient or Responsible Party (Street) _____

(City)_____ (State)_____ (Zip)_____

Phone (cell/home) _____(work)_____Email: _____

Name of DENTIST that referred you to our office: _____

Preferred pharmacy (name and location) _____

**DENTAL INSURANCE**: Carrier Name_____Please present card to be copied

Subscriber: _____SS#_____ dob_____

Employer: _____ Group Number: _____

SECONDARY: Carrier Name: _____Please present card to be copied

Subscriber: _____SS#_____dob_____

Employer: _____ Group Number: _____

I hereby authorize payment directly to Northside Endodontics of the group insurance benefits otherwise payable to me. I authorize the release of any information relating to submitting claims to my insurance carrier.

**Patient/Responsible Party Signature** _____ date: _____

I understand that I am responsible for all costs of dental treatment and that if payment is not made when due, either after insurance pays or per prior payment arrangements made, the account may be turned over for collection. I will also be responsible for any and all costs associated with the collection procedure, including but not limited to billing costs, collection fees, lawyer's fees, and court costs.

**Patient/Responsible Party Signature** _____date: _____

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HIPAA ACKNOWLEDGEMENT

I acknowledge that I have read and was offered or given a copy of the Northside Endodontics Notice of Privacy Practices.

Please list any persons who we may speak to regarding your account, appointments, or dental treatment:

_____, _____, _____

**Patient/Responsible Party Signature** _____date: _____

You may refuse to sign the acknowledgement statement for the Northside Endodontics Notice of Privacy Practices.

I refuse to sign: _____ Reason: _____

**CONFIDENTIAL HEALTH HISTORY**: Circle any of the following which you have had or have at present:

| | | | |
|---|---|---|---|
| AIDS / HIV | Congenital Heart Valve | Hemophilia | Radiation Treatment |
| Anemia | Cortisone Medicine | Hepatitis A, B, C, D | Reflux Disease |
| Anxiety | Diabetes (A1C _____) | High Blood Pressure | Rheumatic Fever |
| Arthritis | Drug Addiction | Kidney Trouble | Sinus Trouble |
| Artificial Joint-_____ | Epilepsy or Seizures | Latex Allergy | Stomach Ulcers |
| Asthma | Excessive/Prolonged Bleeding | Liver Disease | Stroke |
| Blood Transfusion | Heart Murmur | Lung Disease | Thyroid Disease |
| Chemotherapy | Heart pacemaker | Mitral Valve Prolapse | Tuberculosis (TB) |
| Claustrophobia | Heart Trouble | Pain in Jaw Joints/TMJ | Venereal Disease |

HAVE YOU EVER HAD TO PRE-MEDICATE WITH ANTIBIOTICS BEFORE DENTAL TREATMENT OR CLEANINGS?..... YES NO

If yes, reason_____ Name of orthopedist (If applicable) _____

ARE YOU ALLERGIC TO OR MADE SICK BY ANY MEDICATION? (Please list NAME-REACTION) …… YES NO

_____

HAVE YOU EVER HAD A REACTION TO DENTAL ANESTHETIC INJECTION?..... YES NO

DO YOU HAVE ANY DISEASE OR CONDITION NOT LISTED? IF YES, PLEASE EXPLAIN_____

_____

ARE YOU PREGNANT, BREAST-FEEDING?..... YES NO

DO YOU TAKE A BLOOD THINNING MEDICATION?..... YES NO

If yes, name of prescribing doctor_____ INR (If applicable) _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING (including OTC and vitamins) _____

_____

YOUR FAMILY PHYSICIAN NAME AND PHONE NUMBER: _____

In case of emergency please contact: _____

**I have answered these questions to the best of my knowledge:**

**X_____ _____ date_____**

**Patient's Signature (Parent if under 18)** **Print name**

NORTHSIDE ENDODONTICS P.C.