Palmetto Endodontics, LLC

Specialists in Saving Teeth

PATIENT INFORMATION *(Please provide Photo ID with completed paperwork)*

Last Name___________________________________ First Name: ______________________ MI: ______

Please Circle One: Mr. Mrs. Ms. Other_______________

Address: ____ City _______________ State _____ Zip_________

Home Phone:__________________ Work Phone: ___________________ Cell Phone: __________________

Preferred Name: ____________________________ Email: _________________________________

**By providing us with your phone numbers and email address, you consent to being contacted by these methods for appointment related purposes.*

Please Circle One: Male Female SSN: ___________________ Date of Birth: __________________

Name of your Employer: ____

Name of your Referring Dentist: _______________________________________

DENTAL INSURANCE INFORMATION *(Please provide card with completed paperwork)*

Name of Ins Company: ________________________________Employer: ____________________________

Patient's relationship to Subscriber *(Please circle one)*: **POLICY HOLDER SPOUSE CHILD OTHER**

Subscriber's Name EXACTLY as it appears on card: ____

Subscriber's Date of Birth: _________________________ ID/SSN: _________________________

If the patient is a minor, person responsible for payment: ____

PLEASE PROVIDE SECONDARY INSURANCE INFORMATION BELOW (WHEN APPLICABLE)

Name of Ins Company: ____ Employer: ___________________________

Subscriber's Name: ____________________________ SSN/ID#: _______________________ DOB: _______________

HEALTH HISTORY:

Physician's name: ____
Women Only: Are you pregnant or nursing? Yes / No

MEDICATIONS (***Please indicate ALL medications you are currently taking***)

Antibiotic: ______________________________ Cortisone/Steroids: ________________________

Pain Med: ______________________________ Blood Thinners: ___________________________

Heart Med: _____________________________ Blood Pressure: ___________________________

Aspirin: ________________________________ Osteoporosis: _____________________________

Please list any other medications not mentioned above here: ______________________________________

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ALLERGIES (***Please circle ALL allergies***)

Penicillin Demerol Local Anesthetic Sulfa

Codeine Latex Aspirin Erythromycin

Please list any other allergies not mentioned above here: ____
____
____

MEDICAL CONDITIONS (***Please circle ALL medical conditions***)

Heart Condition Diabetes Thyroid/Hormone Disorder

High Blood Pressure Tuberculosis Surgery (Heart/Joint Replacement)

Low Blood Pressure Fainting Stroke

Rheumatic Fever Kidney/Liver/Stomach Epilepsy

Asthma HIV Radiation Treatment/Chemo Therapy

Blood Disorders Hepatitis

Please list any other conditions not mentioned above here: _______________________________________
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EMERGENCY CONTACT INFORMATION:

Name: ____ Telephone: __________________________
Relationship: ____________________________

Palmetto Endodontics, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I have received a copy of this office's Notice of Privacy Practices.

____
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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