

Annapolis Endodontics

Board Certified Endodontists

201 West Street
Annapolis, MD 21401
410-268-4770



Louis H. Berman, D.D.S.
Kenneth R. Hunter, D.D.S.
James O. Roahen, D.D.S.

PATIENT REGISTRATION

Your Name (first name) _____ (middle init) _____ (last name) _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Female Male

Social Security Number _____ General Dentist _____

Home Telephone _____ Referred By _____

Employer / School _____ Work Telephone _____

Spouse's Name _____ Occupation _____

DENTAL INSURANCE

Company Name _____ Who is responsible for this account: _____

Policy Holder _____ Employer _____

Date of Birth _____ Employer's Address _____

Membership Number _____ Work Telephone _____

Group Number _____ Social Security Number _____

Date of Birth _____

MEDICAL HISTORY

Name of your physician _____

Do you require antibiotics before dental treatment? Yes No If yes, give reason below.

Have you been hospitalized in the last 5 years? Yes No If yes, for what? _____

Please list medications you are taking _____

Do you have, or have you had, any of the following? Indicate "yes" with a

- | | |
|---|---|
| <input type="checkbox"/> Allergies (list below) | <input type="checkbox"/> Thyroid or parathyroid condition |
| <input type="checkbox"/> Heart disease (angina, heart attack, bypass) | <input type="checkbox"/> Hepatitis/liver problems |
| <input type="checkbox"/> Pacemaker or artificial valve | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Excessive thirst/urination |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hip or joint replacement |
| <input type="checkbox"/> AIDS, HIV, or high risk | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Lung disease or Tuberculosis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Blood disorder (describe below) | <input type="checkbox"/> Ulcer, Colitis, or G.I. problems |
| <input type="checkbox"/> Excessive bleeding from cut or extraction | <input type="checkbox"/> (Women) Are you pregnant |
| <input type="checkbox"/> Malignancies/ cancer | <input type="checkbox"/> Kidney disorder |
| <input type="checkbox"/> Radiation or chemotherapy treatment | |

Other: Please explain _____

Allergies to medications (for example, Penicillin or "Novocain") _____

Comments: _____

DENTAL HISTORY

Do you feel discomfort when the tooth/teeth in question come in contact with:

Hot foods or liquids (soups, coffee, etc.)? Yes No

Cold foods or liquids (ice cream, cold water, etc.)? Yes No

Sweet or sour food (candy, oranges, fruit, etc.)? Yes No

When you bite down or chew? Yes No

Do any of the above symptoms linger for more than a minute or so? Yes No

Comments: _____

INFORMED CONSENT

We shall try to advise you as to the expected number of appointments necessary, the time needed for each appointment, what you may expect from the treatment, and the fee. It is understood that endodontic treatment is a procedure to retain a tooth which may otherwise require extraction. Although this treatment has a very high degree of clinical success, it is still a biological procedure so it cannot be guaranteed. In the event of non-healing, the patient is still financially responsible for treatment. Occasionally a tooth which has had endodontic treatment may require retreatment, surgery, or even extraction, any of which, and any subsequent treatment, will be the financial responsibility of the patient. Additionally, during the course of treatment, the crown, porcelain or restoration may be damaged or require replacement, which shall be the sole financial responsibility of the patient.

When your treatment is completed, your tooth will need a final restoration (filling, cap, or crown). Our fee does not include this service. Your referring dentist will render this service which is equally important for the preservation of your tooth. The restoration should be placed shortly after treatment is complete.

PAYMENT: It is expected that payment for all treatment be made in full upon completion of treatment.

DENTAL INSURANCE: As a convenience to you, our office will fill out the necessary forms and submit them to your insurance company. However, *we consider each patient responsible for their entire account.* As most insurance companies provide coverage from 50% to 80%, we require *a minimum of 30%* of the fee prior to the completion of your treatment. If your insurance payment is more or less, your account will be adjusted accordingly. All accounts that are more than 60 days overdue will be assessed a finance charge of 15% A.P.R. The signature below verifies patient receipt of Notice of Privacy Practices.

If you have any questions regarding your treatment or fees, we will be happy to discuss them with you. Should you have any concerns between visits or after completion of your treatment, please do not hesitate to call.

PATIENT'S SIGNATURE: _____ **DATE:** _____