PERSONAL INFORMATION:

TODAY'S DATE: _____

GENERAL DENTIST: _____

PATIENT'S NAME _____ BIRTH DATE _____ SS #_____

PATIENT'S WEIGHT _____ MALE OR FEMALE _____ PARENT'S NAME (if patient is a minor) _____

PHONE: Home _____ Cell _____ E-MAIL _____

MAILING ADDRESS _____ CITY _____ ST _____ ZIP_____

MARITAL STATUS _____ OCCUPATION _____ EMPLOYER _____

EMERGENCY CONTACT NAME _____ RELATION _____

ADDRESS _____ PHONE _____

NAME OF PERSON RESPONSIBLE FOR PAYMENT (if other than patient): _____

RELATION _____ SS# _____ BIRTH DATE _____ PHONE _____

DENTAL INSURANCE INFORMATION:

INSURED'S NAME _____ SS# _____RELATION _____ BIRTH DATE _____

ADDRESS (if different than patient) _____

EMPLOYER (even if retired) _____ID# _____ GROUP #_____

INSURANCE CO. _____ PHONE _____

In order to process your insurance, we will need a copy of your dental insurance card and photo ID. We are not a dental provider for all insurance companies. If you have dental insurance that we are NOT providers for, you will need to pay us in full at the time of your appointment.

I certify that I have dental coverage with _____ Insurance Company and I assign directly to Dr. MacIntyre all insurance benefits, otherwise payable to me. I hereby authorize Dr. MacIntyre to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

Signature of the Insured Date

Payment is due at the time services are rendered. We accept Cash, Check, Debit Card, Cherry, Care Credit, and all major credit cards. Returned checks will be subject to a $35.00 service charge. Delinquent accounts may be subject to a service fee. If you have any questions about any of the information, please do not hesitate to ask us. We are here to help you and we are committed to providing you with the best possible care. **If you fail to keep your appointment, you will be charged a $100 fee. If you do not confirm your appointment within 24 hours of the scheduled time, your appointment will be given to the next patient on our list.**

I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this form and have answered the questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ _____

Patient Signature (or Parent Signature if the patient is a minor) Date

CONTINUE ON BACK FOR MEDICAL INFORMATION ⇨

ARE YOU PRESENTLY EXPERIENCING ANY DISCOMFORT IN YOUR TEETH OR MOUTH? Y N

EXPLAIN _____

IS THIS THE RESULT OF AN ACCIDENT? Y N

EXPLAIN_____

MEDICAL HISTORY: DATE OF LAST PHYSICAL EXAM _____ PHYSICIAN'S NAME _____

ARE YOU NOW OR HAVE YOU BEEN RECENTLY UNDER A PHYSICIAN'S CARE? Y N

EXPLAIN _____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS IN THE PAST FIVE (5) YEARS? Y N

EXPLAIN _____

ARE YOU CURRENTLY TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS? PLEASE CIRCLE

ANTIBIOTICS	**CORTISONE DRUGS**	**STEROIDS**	**TRANQUILIZERS**
BLOOD PRESSURE	**BLOOD THINNERS**	**SEDATIVES**	**OTHERS: _____**

ARE YOU ALLERGIC TO OR HAVE YOU EXPERIENCED AN UNUSUAL REACTION TO ANY MEDICATIONS? PLEASE CIRCLE

PENICILLIN	**CODEINE**	**ASPIRIN**	**SULFA**
DENTAL ANESTHESIA	**LATEX**	**OTHERS: _____**	

HAVE YOU EVER BEEN TOLD TO TAKE ANTIBIOTICS *BEFORE* ANY DENTAL TREATMENT? Y N

IF YES, WHAT ANTIBIOTICS DO YOU TAKE? _____

WOMEN ONLY: ARE YOU PREGNANT? Y N Unsure If yes, # of weeks or months _____ **BREASTFEEDING? Y N**
ARE YOU TAKING BIRTH CONTROL PILLS, DEPO SHOTS, IMPLANT BC, OR HORMONE THERAPY (HRT)? Y N
EXPLAIN _____

ANSWER *ALL* OF THE BELOW: **(Y)** YES **(N)** NO **(DK)** DON'T KNOW

ABNORMAL BLEEDING	**Y**	**N**	**DK**	**HIGH OR LOW BLOOD PRESSURE (CIRCLE WHICH ONE)**	**Y**	**N**	**DK**
ANEMIA	**Y**	**N**	**DK**	**HIV+/AIDS**	**Y**	**N**	**DK**
ARTHRITIS	**Y**	**N**	**DK**	**HIVES (CAUSE) _____**	**Y**	**N**	**DK**
ARTIFICIAL JOINTS	**Y**	**N**	**DK**	**INFECTIVE ENDOCARDITIS**	**Y**	**N**	**DK**
ASTHMA OR HAY FEVER	**Y**	**N**	**DK**	**KIDNEY OR BLADDER PROBLEMS**	**Y**	**N**	**DK**
BLOOD DISEASE OR TREATMENT	**Y**	**N**	**DK**	**LIVER PROBLEMS**	**Y**	**N**	**DK**
CANCER OR TUMOR	**Y**	**N**	**DK**	**LUNG DISEASE**	**Y**	**N**	**DK**
CHEMOTHERAPY OR RADIATION THERAPY	**Y**	**N**	**DK**	**PERSISTENT COUGH**	**Y**	**N**	**DK**
CHEST PAIN	**Y**	**N**	**DK**	**SEIZURES**	**Y**	**N**	**DK**
DIABETES (INSULIN OR MEDICINE)	**Y**	**N**	**DK**	**SINUS PROBLEMS**	**Y**	**N**	**DK**
DIFFICULTY BREATHING	**Y**	**N**	**DK**	**STEROID THERAPY**	**Y**	**N**	**DK**
EPILEPSY	**Y**	**N**	**DK**	**STROKE**	**Y**	**N**	**DK**
FAINTING SPELLS (POTS)	**Y**	**N**	**DK**	**THYROID PROBLEMS**	**Y**	**N**	**DK**
GLAUCOMA	**Y**	**N**	**DK**	**TUBERCULOSIS (TB)**	**Y**	**N**	**DK**
HEART TROUBLE	**Y**	**N**	**DK**	**ULCERS**	**Y**	**N**	**DK**
HEPATITIS TYPE ____	**Y**	**N**	**DK**	**SEXUALLY TRANSMITTED DISEASE (STD)**	**Y**	**N**	**DK**
HERPES ___, SHINGLES, ZOSTER	**Y**	**N**	**DK**	**OTHER _____**			

PLEASE LIST ANY SERIOUS MEDICAL CONDITION(S) YOU HAVE EXPERIENCED THAT HAS NOT BEEN ASKED

Roderick M. MacIntyre, DMD, MS
Practice Limited to Endodontics
912 S. Ridgewood Avenue, Ste. C
Daytona Beach, FL 32114
386.252.0858

Patient Office Policy

1. For your Endodontic Treatment to be successful, ***it is essential that you contact your general dentist within one (1) week to seal and crown the tooth.*** We cannot be responsible if you do not follow this procedure.
2. If you do not follow up with your general dentist within the allotted time frame, you may be required to obtain another root canal treatment (a re-treatment) of the same tooth at a higher cost.
3. If you fail to come to your appointment or give 24-hour notice to cancel or reschedule, you will be assessed an additional $100 fee. We may ask you to seek Endodontic Treatment with another provider in the area.

I have read and understand these policies.

_____ _____

Patient/Guardian Signature Date

Notice of Privacy Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers (medical and dental) who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that a copy of the ***Notice of Privacy Practices*** containing a more complete description of the disclosures of my health information has been made available to me. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices***. I consent to your disclosure of my information, which you deem necessary in connection with my treatment. HIPPA prevents us from disclosing any information about you to anyone (other than your medical and dental providers) without your permission.

List anyone (significant other, family member, etc.) to whom we can release information regarding your treatment:

_____ _____

In accordance with HIPAA Guidelines, we must have permission to call you and/or leave a message. Please update all the ways we may get in touch with you on your Patient Information Form.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restriction.

Patient Name (please print): _____

Patient/Guardian Signature: _____Relationship_____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so as documented below:

Date	Initials	Reason

East Coast Endodontics, Inc
Roderick M. MacIntyre, III, D.M.D., M.S. and Associates

Roderick M. MacIntyre, DMD, MS
912 S. Ridgewood Avenue, Ste. C
Daytona Beach, FL 32114
386.252.0858 Fax: 386.253-7004
ecefrontdesk@outlook.com

Insurance Payment Policy

Thank you for choosing East Coast Endodontics as your endodontic dental provider. Our goal is to make your experience with Dr. MacIntyre successful. Part of this experience includes the payment of your bill.

Please read our insurance payment policy before Dr. MacIntyre begins your procedure.

Charges: Our practice is committed to providing the best treatment for our patients. We charge what is "reasonable and customary" for our area. You are responsible for payment regardless of any insurance company's determination of "usual and customary" charges.

Insurance: It is necessary for you to supply us with all the insurance information requested for us to file a claim for you. We will speak with your insurance provider who will tell us the following information:

- Percentage of coverage and your co-pay for the procedure.
- Your deductible amount (if any) and whether it has been met.
- Issuance date of the policy.
- Limits of coverage for the calendar year.

There are instances when an insurance provider will not cover "out of network" or even some "in network" treatments. Therefore, it is the patient's financial responsibility to pay for the treatment in full should the insurance refuse to cover the procedure(s).

In the unlikely event the insurance company sends the reimbursement check to you rather than to East Coast Endodontics, it is your responsibility to bring or mail it to us immediately. If the insurance company sends payment to our office that is more than was expected, we will issue a refund to you for the extra amount as soon as possible.

I have read, understand, and agree with this policy.

_____
Patient Name (printed)

_____ _____
Signature of Patient or Responsible Party Date

Revised 08/26