ENDODONTIC ASSOCIATES OF SOUTHERN INDIANA

Scott E. Shuler, D.M.D., M.S.
Jennifer I Kron, D.M.D.
392 South Indiana Ave
Sellersburg, Indiana 47172
(812) 945-3636

Name_____ Date_____

Date of Birth_____

Have there been any significant changes in your health during the past year? □ Y □ N
If so, please specify.

_____

Please check any that apply:

□ Heart Murmur Does the murmur require premedication for dental treatment? □ Y □ N
□ Rheumatic Fever
□ Heart Attack How long ago? _____
□ High Blood Pressure
□ Epilepsy/Seizures
□ Hormone Replacement
□ Bleeding Disorder
□ Asthma
□ Osteoporosis
□ Diabetes
□ Stomach Ulcers
□ Kidney Disease
□ Radiation Therapy
□ HIV/AIDS/Hepatitis (Circle)
□ Joint Replacement

Drug Allergy (Rash, Hives or Breathing Difficulty):
Please check: □ Penicillin □ Sulfa □ Iodine □ Codeine □ Epinephrine □ Latex
□ Other (Please list) _____

Please list all medications you are currently taking, with dosages (if known):

_____

_____

_____

Who is your family physician (that is, who would have the most current medical records should we need to consult them concerning some aspect of your treatment?)

_____

Do you smoke? □ Y □ N Do you use any other tobacco product regularly? □ Y □ N

WOMEN:
Could you be pregnant right now? □ Y □ N
Are you taking birth control medication? □ Y □ N

Informed Consent:

I, the undersigned, consent to thorough evaluation by Endodontic Associates, including any necessary imaging and clinical testing necessary to investigate my chief complaint. Prior to initiation of treatment, informed consent will be obtained for any procedures to be performed. I also understand that all health and personal information provided will be used in a manner consistent with federal privacy regulations, and that a copy of this office's policy practices will be furnished upon my request.

Signature: _____ Date: _____

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Please print the following information:

Name (First, MI, Last): _____ Date: _____

Address: _____ Date of Birth: _____

City/ST/Zip: _____ Marital Status: _____

Social Security #: _____ Employer: _____

Home Telephone: _____ Business Telephone: _____

Referring Dentist: _____ Your Cell Phone: _____

Responsible Party: _____ Date of Birth: _____ Social Security #: _____

Payment is due at the time of treatment. For your convenience, we accept cash, personal check, Mastercard, Visa, Discover, and Care Credit.

If you are covered by dental insurance, we are happy to file this as a courtesy to you. We ask that you provide us with a copy of your insurance card for our records. We will attempt to verify the amount of your insurance benefit before or during your appointment, so that you can make any applicable co-payment at the time of your treatment. Please understand this insurance and co-payment information is an ***Estimate Only***, not a guarantee of coverage or payment by the insurance company. If no payment is received from your insurance company within 90 days, the balance becomes the responsible party's.

Collection activity will not be pursued until 30 days after settlement of any outstanding insurance claim, and reasonable attempt has been made to contact you to discuss payment. In the case of default of payment, you are responsible to pay any legal interest on balance due, together with any collection costs and attorney fees incurred to effect collection on your account.

This office will provide a copy of the HIPPA Privacy Practice upon request. Received ____
Declined ____

Dental Insurance Company: _____ Secondary: _____
Insured's Name: _____ _____
Date of Birth: _____ _____
ID. #: _____ _____
Group #_____ _____
Which of the following forms of payment will you be using?
Methods of payment: □ Cash □ Check □ Credit Card

ESTIMATED PAYMENT FOR TODAY _____

Signature: _____ Date: _____