Princeton Endodontics
Patient Information & Health History
601Ewing Street Suite A-10 Princeton, NJ 08540
609.497.1188

Name _____Date_____
Address _____
Phone #'s: home_____cell_____work_____
Social Security #_____ DOB_____ AGE___ M__ F __
Marital Status _____ Spouse Name_____
Employer_____ Physician's Name_____
Dentist and/or Specialist's Name(s) _____
Emergency Contact_____( )___-____rel._____

Dental Insurance Information: Company_____
Employer_____ Group#_____ ID#_____
Subscriber_____ Subscriber DOB _____

Medical History

Females: are you pregnant or nursing?_____
Current Medications_____
Are you allergic to Penicillin? Y___N___ Latex? Y___ N___
Other Drug Allergies?_____
Have you ever had any unusual reaction to an anesthetic or Drug?_____
_____

Please circle any illness you have or had:

HIV/AIDS	Epilepsy	Heart Disease	Rheumatic Fever
Asthma	Glaucoma	Hepatitis	Tuberculosis
Diabetes	Kidney/Liver	Blood Pressure	Drug/Alcohol

Do you need to pre-medicate with antibiotics 1 hour prior to dental treatment? No or not anymore_____ Yes because I have (circle one)

Prosthetic Valve	Congenital Heart Disease	Endocarditis
Cardiac Transplant	Prosthetic Joint	Other_____

Is there any other information that the doctor should know about your health?_____

(continue on reverse)

Do you have any special requests, concerns or past experiences that you would like to share with Dr. Leveson? _____
_____

What pharmacy do you use? _____phone_____

Can messages be left on any of your voicemails?_____
Do you prefer text messages? _____number_____
My email address (optional)_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. Since providing inaccurate information can be dangerous to my health, the above questions have been answered to the best of my ability. I authorize the endodontist to release any information including, but not limited to, the diagnosis and records of any treatment or examination to third party payers and/or health practitioners. I understand that my dental insurance carrier may pay less than the acutual bill for services, yet agree to pay for all services rendered on my behalf. In addition, I have read and understand the *Notice of Privacy Practices* (HIPPA) that detail the use and disclosure of my private information.

Date_____
Signature of Patient (guardian if minor)

Patient's Payment Resposibility

I understand that I am financially responsible for all medical/dental bills incurred while under the care of the Doctors of Princeton Endodontics. In the event that my account is not paid after 60 days, I will be subject to a finance charge of 1.5% per month, 18% per year, which will be added to account balances. Balances over 90 days will be subject to collection proceedings. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I further understand that there will be a $20.00 charge (or the equivalent of the bank's penalty fee) for any returned checks from the bank for non-sufficient funds. My signature below indicates that I have read and understand the above terms and conditions.

Date_____
Signature of Patient (guardian if minor)