REGISTRATION

Brian Amoroso, DDS • *Practice Limited to Endodontics*

PLEASE PRINT CLEARLY

Name First _____ Last _____ MI _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number *(required by most Insurance Carriers)* _____

Phone: Home _____ Work _____ Cell _____

Preference: ☐ Home ☐ Work ☐ Cell

Employer _____ Occupation _____

Referred by _____

In case of emergency, please contact _____ Phone _____ Relationship _____

MEDICAL HISTORY: Are you in good health? ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No If so, for what _____

Physician's name and town _____

Are you currently taking medications? ☐ Yes ☐ No If so, please list _____

_____

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR HEALTH:

☐ Heart Murmur / MVP	☐ Prosthesis / Joint	☐ Respiratory	☐ Mental Illness	☐ Seizures	☐ Osteoporosis
☐ Rheumatic Fever	☐ Diabetes	☐ Sinusitus	☐ Depression	☐ STD	☐ Pregnant
☐ High Blood Pressure	☐ Hepatitis	☐ Kidney Disease	☐ Cancer	☐ Liver	☐ I Have Had Previous Root Canal Treatment
☐ Heart Trouble	☐ AIDS / HIV	☐ Tuberculosis	☐ Pacemaker	☐ Bleeding	
☐ Tumor / Growth	☐ Asthma	☐ Ulcer / Colitis	☐ Thyroid	☐ Allergy _____	

Have you had an unusual response to an anesthetic or drug? ☐ Yes ☐ No If so, please list _____

Other pertinent medical information: _____

INSURANCE: ***Our professional treatment is rendered to you, not the insurance company; you are directly responsible to us for the obligation of payment for treatment.*** This office does not accept assignment of benefits. However, we will gladly assist you in completing an ADA universal claim form so that your plan may properly reimburse you according to the terms of your policy.

PAYMENT: ***Full payment is required upon completion of treatment***. In the event of a multiple visit treatment, the initial payment is one-half of the total fee with the balance due by completion. Should you have any questions or concerns regarding payment, please discuss them with us prior to your care.

ENDODONTIC INFORMED CONSENT: I understand the goal of endodontic treatment is to retain a tooth that may otherwise require extraction. Although endodontic treatment has a high degree of clinical success, it is a dental-biological procedure, therefore results cannot be guaranteed. Some of the possible risks include, but are not necessarily limited to, the following: discomfort, swelling, fever, infection, bleeding, bruising, altered sensations, difficulty opening or closing the mouth, or loss of the tooth. I agree to notify my restorative dentist immediately following completion of root canal treatment so that a restoration (crown, filling, onlay, etc.) may be placed. Failure of prompt restorative treatment may lead to fracture and/or loss of a treated tooth.

HIPAA CONSENT: Due to FEDERAL MANDATES called *Health Insurance Portability and Accountability Act*, or *HIPAA*, Healthcare providers are now required to obtain ***patient consent*** for the release of private health information. The release of information may be to your physician, referring dentist or insurance company and includes permission to leave appointment reminders on your message machine at home, work or cell phone, or contact you via postcard or letter.

I hereby give Dr. Brian Amoroso, DDS, and staff, consent to release information for the benefit of my care.

Signed: Patient or Guardian _____ Date _____