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Hiltz Endodontics
Root Canal & Microsurgical Specialist
1664 East Chocolate Ave. Hershey, PA 17033
717.707.2300

Patient Information

Date:_____
Patient Name:_____
Nickname:_____
Address:_____
City:_____State:_____ Zip:_____
Birth Date:_____ Male:_____ Female:_____
Phone: _____ Cell:_____Work:_____
Employer:_____
Occupation:_____
Emergency Contact:_____Phone:_____
Your email address:_____
General Dentist Name:_____

Dental Insurance information

Primary Carrier
Insurance Company Name:_____
Address:_____
Policy Holder's Name:_____
Identification Number:_____
Birth Date:_____Group #_____
Employer Name:_____

Secondary Carrier
Insurance Company Name:_____
Address:_____
Policy Holder's Name:_____
Identification Number:_____
Birth Date:_____Group #_____
Employer Name:_____

Medical History

Have you had or do you currently have any of the following:

High Blood Pressure	**Yes**	**No**	**Irritable Bowel**	**Yes**	**No**
Heart Issues	**Yes**	**No**	**Colitis**	**Yes**	**No**
Heart Murmur	**Yes**	**No**	**Herpes**	**Yes**	**No**
Angina	**Yes**	**No**	**HIV/AIDS**	**Yes**	**No**
Stroke	**Yes**	**No**	**Osteoporosis**	**Yes**	**No**
Mitral Valve Prolapse	**Yes**	**No**	**Fainting Spells**	**Yes**	**No**
Congenital heart	**Yes**	**No**	**Arthritis**	**Yes**	**No**
Anemia	**Yes**	**No**	**Kidney Issues**	**Yes**	**No**
Migraines	**Yes**	**No**	**Blood Disorders**	**Yes**	**No**
Pacemaker	**Yes**	**No**	**Lung Disease**	**Yes**	**No**
Tuberculosis	**Yes**	**No**	**Diabetes**	**Yes**	**No**
Convulsions	**Yes**	**No**	**Psychiatric Care**	**Yes**	**No**
Thyroid Issues	**Yes**	**No**	**Joint Replacement**	**Yes**	**No**
Epilepsy	**Yes**	**No**	**Cancer**	**Yes**	**No**
Hepatitis A,B,C	**Yes**	**No**	**Radiation Treatment**	**Yes**	**No**
Substance Abuse	**Yes**	**No**	**Artificial Heart Valve**	**Yes**	**No**

OTHER:_____

Are you <u>ALLERGIC</u> to any of following:

Penicillin/Amoxicillin	**Yes**	**No**	**Sedatives**	**Yes**	**No**
Sulfa Drugs	**Yes**	**No**	**Barbiturates**	**Yes**	**No**
Erythromycin	**Yes**	**No**	**Steroids**	**Yes**	**No**
Clindamycin	**Yes**	**No**	**Novacaine**	**Yes**	**No**
Motrin/Advil	**Yes**	**No**	**Vicodin**	**Yes**	**No**
Aleve	**Yes**	**No**	**Valium**	**Yes**	**No**
Aspirin	**Yes**	**No**	**Latex**	**Yes**	**No**
Codeine	**Yes**	**No**	**OTHER:**_____		

_____

General Health: **Excellent** **Good** **Fair** **Poor**

Name of your family Physician:_____

Please list medications you are taking:_____

Have you ever had a root canal? **Yes** **No**

Are you pregnant? **Yes** **No** **Months**_____

Do you Premedicate with antibiotics before dental treatment due to any type of prosthetics, joint replacement or heart condition? **Yes** **No**

Do you take a blood thinner? **Yes** **No**

Are you or have you taken a bisphosphonate such as Fosamax, Actenol or Boniva? **Yes** **No**

Is there anything else we need to know about your health?_____

_____

Patient Signature *(guardian)*:_____ **Date:**_____

<u>Office Use Only:</u> **Medical History Reviewed:**_____**Date:**_____

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Financial Policy and Release of Benefits

We are committed to providing you with the best possible care in a timely matter. Your understanding of our Financial Policy and fees are important to our professional relationship.

Insurance

Dental insurance is a contract between you and your insurance company. It is your responsibility to understand your limits and the extent of your coverage. Please provide us with the accurate information to process your claim efficiently. **Hiltz Endodontics is a participating provider with the following dental insurance companies: United Concordia, Delta Dental, Blue Cross Dental, UPMC Dental, and Aetna Dental.**

We are not a Medicare Provider, therefore we can not submit a claim to Medicare on your behalf.

****If you have an insurance that we Do Not participate with or No Dental Coverage the total fee is required at the time of treatment.** We do accept MasterCard, VISA, Discover and American Express. A **5% courtesy** is offered for patients paying with check or cash. A **3% courtesy** is offered for credit card payments.

For those insurance companies we do not participate with and you have provided the proper information **Hiltz Endodontics** will submit the claim to your insurance company on your behalf.

Appointments

Patients who cannot make their scheduled appointment are expected to give a 24 hour notice. Broken appointments give **Hiltz Endodontics** the right to dismiss patients from the practice.

Release and Assignment of Benefits

I hereby authorize **Hiltz Endodontics** to release to the insurance company or its representative any information including diagnosis and records of any treatment or examination rendered to me.

Signature:_____

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ANY SERVICES RENDERED

Signature:_____

Date:_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving consent

NAME:_____

ADDRESS:_____

PHONE:_____ SOCIAL SECURITY NUMBER_____

Section B: To the patient--- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of this Notice of Privacy Practices, including revisions of our Notices at any time by contacting:

Privacy Officer
Hiltz Endodontics
1664 East Chocolate Ave. Hershey, PA 17033

SIGNATURE:

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature:_____ **Date:**_____

****If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name:_____

Relationship to the Patient :_____

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.