RICHARD J. DELLORK, D.D.S.

PRACTICE LIMITED TO ENDODONTICS

Name & Address

Last:_____

First:_____

Middle:_____ Title:_____

Address:_____

City:_____ State:_____ Zip:_____

Insurance

Employer:_____

Insurance Company:_____

Claims Address:_____

_____

Phone Number: (_____)_____

Subscriber Name:_____

Subscriber ID#:_____

Subscriber Birth Date:_____

Group Number:_____

Patient's Relationship to Subscriber:_____

Personal

☐ Home: (_____)_____

☐ Work: (_____)_____

☐ Cell: (_____)_____

☐ E-Mail: _____

(Please check your preferred method(s) of contact.)

SS #: _____

DOB: _____/_____/_____

Sex: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

General Dentist:_____

Who referred you to our office?

_____

(If someone other than your general dentist.)

Allergies

Are you allergic to or do you suffer ill effects from any of the following:

☐ Penicillin ☐ Aspirin ☐ Codeine

☐ Sulfa ☐ Dental Anesthesia ☐ Latex

☐ None ☐ Other:_____

Emergency Contact

Name:_____ Relationship:_____ Phone: (_____)_____

Medical History

Is this visit the result of an accident?_____ If yes, when did accident occur?_____

Do you see a physician routinely for a medical condition? _____ If yes, Reason? _____

_____

(OVER)

Medical History

Check any of the following that you have had or suspected:

☐ Prosthetic Joint Replacement	☐ Mitral Valve Prolapse	☐ Heart Trouble/ Murmur	☐ Rheumatic Fever
☐ Arthritis	☐ Liver Disease	☐ Epilepsy	☐ Pacemaker
☐ Chest Pain	☐ Mental Disorder	☐ Venereal Disease	☐ Sinus Trouble
☐ Blood Disease	☐ Diabetes	☐ Blood Transfusion	☐ Hepatitis
☐ Jaundice	☐ Fainting Tendency	☐ Tuberculosis	☐ Glaucoma
☐ Radiation Treatment	☐ Lung Disease	☐ Asthma/ Hay Fever	☐ Anemia
☐ Kidney/ Bladder Trouble	☐ HIV/ AIDS	☐ Prolonged Bleeding	☐ Cancer/ Tumor
☐ Thyroid Disease	☐ Stroke	☐ Shortness of Breath	☐ Gastrointestinal Disorder
☐ Low Blood Pressure	☐ High Blood Pressure	☐ Clench/ Grind of Teeth	☐ Other:_____

Dental Anxiety Level ☐ Not Anxious ☐ Slightly Anxious ☐ Extremely Anxious

Prescriptions

Check any of the following that you are currently taking:

☐ Cortisone/ Steroids ☐ Sedatives / Tranquilizers ☐ Anticoagulants/ Blood Thinners

☐ Pain Reliever: _____ ☐ Antibiotics: _____

Other Medications Taken Routinely: _____

Women Only: Are you pregnant? _____ If so, how many months? _____

Are you breastfeeding? _____

Do you take any medication routinely? (Birth Control/Hormone Therapy)_____

I am aware that the office of Richard J. Dellork, DDS utilizes the most current Privacy Practices. **I hereby authorize the office to affix my name to any & all forms or documents as related to my protected health information**. I am aware that the Privacy Policy is located in the office and on the office website to view at any time. Only by request will a written copy of the Privacy Policy be given to me. I may refuse to sign this acknowledgement. If I refuse, the office will document the refusal following proper practice policy.

I hereby authorize the office to affix my name on any & all insurance claims & documents as related to my health benefits due to me or my dependants. I authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I agree to be responsible for all charges for dental services not paid by my insurance plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. **I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due & payable at the time services are rendered unless other arrangements are made.** If it becomes necessary to refer my account to an attorney for collection, I agree to pay a 1 1/2% finance charge (18% APR), attorney's fees in the amount of one-third (33.3%) of the principal amount of the unpaid balance and any other collection charges. I authorize the office to affix my name to any & all documents turned over to collections. **In addition, there will be a $30.00 charge for any returned checks and a $125.00 charge for a broken appointment within 24 hours notice.**

I am aware that Dr. Dellork is an Endodontist (Root Canal Specialist) and that he provides Root Canal Treatment ONLY. Although this treatment has a high degree of success, it cannot be guaranteed. Occasionally a tooth will require retreatment, surgery, or even extraction. After the Root Canal is completed, I understand that I am to return to my general dentist for final restoration, which is needed to prevent tooth deterioration. This usually consists of a crown or filling. Your dentist will advise you as to what is best for your tooth.

I have read and understand the above information and have answered all questions truthfully to the best of my knowledge.

Signature: _____ Date: _____