

RICHARD J. DELLORK, D.D.S.

PRACTICE LIMITED TO ENDODONTICS

30 YEARS SERVING NORTHERN VIRGINIA

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:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Prosthetic Joint Replacement | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Heart Trouble/ Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Fainting Tendency | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Asthma/ Hay Fever | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Kidney/ Bladder Trouble | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Cancer/ Tumor |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Gastrointestinal Disorder |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Clench/ Grind of Teeth | <input type="checkbox"/> Other: _____ |
- Dental Anxiety Level** Not Anxious Slightly Anxious Extremely Anxious

Prescriptions

Check any of the following that you are currently taking:

- | | | |
|--|--|---|
| <input type="checkbox"/> Cortisone/ Steroids | <input type="checkbox"/> Sedatives / Tranquilizers | <input type="checkbox"/> Anticoagulants/ Blood Thinners |
| <input type="checkbox"/> Pain Reliever: | | <input type="checkbox"/> Antibiotics: |

List Additional Medications Taken Routinely:

Women Only:

Are you pregnant? _____

If so, how many months? _____

Are you breastfeeding? _____

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: _____