D.K. FAGUNDES ENDODONTICS

105 Parker Dr., Ste. A. LaGrange, GA 30240 · (706) 884-3636
westgarootcanal.com

PATIENT INFORMATION

****PLEASE PROVIDE I.D. & DENTAL INSURANCE CARDS TO FRONT DESK****

*Please rate your pain currently 0-10, (10 worst) 0 1 2 3 4 5 6 7 8 9 10

Patient Name:_______________ General Dentist: _______________
(If P.O. Box, please give street address also)

Address:_______________

City:_______________ State:__________ Zip:__________ E-Mail:_______________

Home Phone: _______________ Work:_______________ Cell: _______________

SSN: _______________ Date of Birth: _______________

Employer: _______________ Address: _______________

Marital Status: _______________ Spouse: _______________Phone: _______________

Spouse's Employer/Address: _______________ Emp. Phone: _______________

EMERGENCY Contact: _______________ Phone: _______________Rel to pt:_______________

RESPONSIBLE PARTY INFORMATION: (if other than the patient)
NAME:_______________Social: _______________
Address:_______________
Home Phone: _______________ Work Phone: _______________ Cell: _______________
Place of Employment_______________
***** Relationship to patient_______________

PRIMARY DENTAL INSURANCE COMPANY: _______________

Policy Holder's Name: _______________ Birthdate: __________ SSN:_______________

Employer: _______________ Relationship to Patient:_______________

Group # : _______________ Individual I D # : _______________ Ins. Phone # : _______________

Ins. Address: _______________ City: __________ State: __________ Zip: __________

SECONDARY DENTAL INSURANCE COMPANY: _______________

Policy Holder's Name: _______________ Birthdate: __________ SSN:_______________

Employer: _______________ Relationship to Patient: _______________

Group # : _______________ Individual I D # : _______________ Ins. Phone # : _______________

Ins. Address: _______________ City: __________ State: __________ Zip: __________

I hereby authorize release of any information regarding my own or my dependant's dental claims and I authorize payment of my insurance benefits directly to D. K. Fagundes, D.M.D., M.S., P.C. for any claims submitted for work performed by Dr. Fagundes for me or my dependants.

Signed: **X**_______________ Date: _______________

D. K. Fagundes, D.M.D., M.S., P.C.

OFFICE PAYMENT POLICY

Payment is expected at the time of service for any amounts not expected to be covered by your insurance. We will file DENTAL insurance claims as a courtesy to you. The amount we collect as a co-pay is an **ESTIMATE.** You are responsible for any balance due after your insurance has paid. The patient, not the insurance company, is responsible for the payment of fees for our services.

I will pay today by: cash ___ check ___ Debit/Credit Card ___ Care Credit _____ Other ___________

I have read and understand the payment policy. I understand that the responsibility for payment for dental services provided in this office for myself or my dependents is mine. I agree to pay all collection agency fees,(33,33%), attorney fees and/or court costs associated with the process of collecting a delinquent account. Any account over 30 days past due will be assessed a monthly billing charge equal to 1 ½% of the unpaid balance (18% annually).

You agree, in order for us to service your account or to collect monies you may owe, D K Fagundes, DMD, MS,PC, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

Signature:**X**____ Date __________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I, ___________________________________, have received a copy of this office's Notice of
(please print name)
Privacy Practices.

Patient's Signature:**X**____________________________________ Date: ______________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign
__ Communications barriers prohibited obtaining the acknowledgement
__ An emergency prevented us from obtaining acknowledgement
__ Other (Please Specify) ____

____

D. K. Fagundes, D.M.D., M.S., P.C.
Patient Medical History

1. Has there been any change in your general health within the past year? . . . . Yes ____ No _____
Please specify____

2. Are you under the care of a physician for a current problem? . . . . Yes ____ No _____
Nature of treatment____
Physician's Name/Phone____

3. Have you been hospitalized within the past five years? . . . . Yes ____ No _____
Reason____

4. Are you taking any medications or drugs? . . . . Yes ____ No _____
Please list:____
____

5. Do you take aspirin? . . . . Yes____ No _____
Reason:____

6. Have you received therapy for alcoholism or drug addiction during the past five years? Yes ____ No ____

7. Have you ever had any **ALLERGY OR ADVERSE REACTIONS** to anesthetics, antibiotics, or other medications? **(if yes, please mark on reverse side of this form)** . . . . Yes____ No_____

8. Have you had abnormal bleeding with previous extractions, surgery, or trauma? . Yes___ No____

9. Have you ever required a blood transfusion? If so, please explain: ___________ Yes___ No____
____Year:_______

10. Have you ever had surgery and /or radiation? Yes____ No____ When/Why: __________________
____

11. Date of your last physical exam:________________________

12. Do you use tobacco products? _____ How long?________ How much per day?_________________

13. Have you ever taken any of the following drugs: **Fen-Phen** (Fenfluramine & Phentermine), **Aredia, Zometa** or **Fosamax**? ___________ If so, when and for how long? ______________________________

14. Do you have a heart condition (mitral valve prolapse, etc.), an artificial joint or other condition ***that requires you to pre-medicate*** with antibiotics prior to dental treatment? . . . . Yes____ No ____

Reason:____

Women:
15. Are you, or do you think you may be, pregnant? . . . . Yes___ No___
16. Are you nursing? . . . . Yes___ No___
17. Do you take birth control pills? . . . . Yes___ No___
IF YES, be advised that if you take antibiotics, an alternate method of birth control must be used.

Please check all that apply:

☐ High Cholesterol	☐ Ulcers/Digestive	**Allergies**	**Medications**
☐ Sinus/Allergies	☐ Migraine/Headaches	☐ Penicillin	☐ No Meds
☐ High Blood Pressure	☐ Seizures/Fainting	☐ Other Antibiotics	☐ Antibiotic
☐ Respiratory/Asthma	☐ Glaucoma/Visual	☐ Aspirin/Ibuprofen	☐ Pain Medicine
☐ Rheumatic Fever	☐ Mental/Neural	☐ Tylenol	☐ Heart Medicine
☐ Circulatory	☐ Tumor/Neoplasms	☐ Codeine	☐ Aspirin
☐ Immunocomprised	☐ Alcoholism/Addiction	☐ Narcotics	☐ Cortisone/Steriods
☐ Anemia/Bleeding	☐ Infectious Diseases	☐ Local Anesth	☐ Blood Thinner
☐ Diabetes	☐ Venereal Disease	☐ Latex	☐ Blood Pressure
☐ IV Drug use	☐ Psychiatric Care	☐ Sulfa	☐ Thyroid
☐ Thyroid/Hormonal	☐ TMJ	☐ Nitrous	☐ Birth Control
☐ Hypoglycemia	☐ Kidney	☐ Food	☐ Hormone
☐ Shortness of Breath	☐ Epilepsy/Fainting	☐ Other	☐ Insulin
☐ Cancer	☐ Joint Replacement	☐	☐ Ulcer/Nexium
☐ Radiation/Chemo	☐ Prosthetic Implant	☐	☐ Antidepressants
☐ Tuberculosis	☐ Heart Disease	☐	☐ Bone Related
☐ Fatigue	☐ Heart Murmur/Defect	☐	☐ Fen-Phen
☐ Arthritis	☐ Pacemaker	☐	☐ Diet Medication
☐ Autoimm- Sjogren's e	☐ Heart Attack/Stroke	☐	☐ Cholesterol Meds
☐ Hepatitis,Jaundice	☐ Irregular Heart Beat	☐	☐ Aredia or Zometa
☐ HIV	☐ Smoking	☐	☐ Fosamax

18. Do you have any disease, condition, or problem not listed above? . . . . Yes___ No___
If yes, please specify:____

____

All the above information is complete and true to the best of my knowledge. I understand that it is my responsibility to inform the dental office of any changes in my medical status, or that of my dependants.

Date: ________________________

Signature of Patient*
*all signatures must be by parent or guardian if patient is under the age of 18.

X ____

Record updates:

Date: Signature:

________________________ ____

________________________ ____

________________________ ____