Joseph A Herbst, D.D.S., F.A.C.D.
Diplomate, American Board of Endodontics

Laurel Pines Professional Bldg
301-604-5550

Patient Registration

Patient's Name(First)__________________Middle___________Last ___________________
Address____
City____________________________________State________Zipcode_________________
Date of Birth____Male_____ Female____

Parent or Guardian's Name (If patient is a minor)First_________________ Middle_________ Last_____________________
(If Patient is a Minor, please give Parent or Guardian's following Information)
Social Security Number____
Home Phone Number____
Work Phone Number____
Cell Number____
Occupation____
Employer____
Work Address____
Married____ Single____
Spouse's Name____
Spouse's Employer____

General Dentist Name____
Address____
Phone Number____
How were you referred?____

DENTAL INSURANCE

Name of Person Responsible for this Account?___________________________________

Policy Holder____

Date of Birth____

Insurance Company____

Subscriber ID#____

Social Security#____

Group #____

Employer____

I hereby authorize release of information necessary to process all insurance claims, if applicable, and request the payment of benefits directly to Joseph A. Herbst, D.D.S. I understand that I am fully responsible to pay all charges incurred for services rendered regardless of insurance coverage. Joseph A. Herbst, D.D.S. will process my insurance as a courtesy to me. In the event of an unpaid bill, then I agree to pay Joseph A. Herbst, D.D.S. all costs and finance fees incurred to collect the bill.

****Please provide us with your insurance card and photo Identification Card.****

____ ______________________________
Signature **Date**

____ ______________________________
Please print name **Relationship to patient (if applicable)**

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Informed Consent

We shall try to advise you as to the expected number of appointments necessary, the time needed for each appointment, what you may expect from the treatment, and the fee. It is understood that endodontic treatment is a procedure to retain a tooth which may otherwise require extraction. Although this treatment has a very high degree of clinical success, it is still a biological procedure so it cannot be guaranteed. Occasionally a tooth which has had endodontic treatment may require retreatment, surgery, or even extraction. Even with the best treatment approximately 5% of endodontically treated teeth may eventually require extraction.

When your treatment is completed, <u>your tooth will need a final restoration</u> (filling or crown). Our fee does not include this service. Your referring dentist will render this service which is equally important for the preservation of your tooth. The restoration should be placed a few weeks after treatment is complete. We will send a report of your treatment to your dentist.

DENTAL INSURANCE: As a convenience to you, our office will fill out the necessary forms and submit them to your insurance company. Most insurance companies provide coverage from 50% to 80%. Your coverage may be less depending upon remaining coverage, deductible, procedures not covered by insurance but are billable to you and other items. We require a minimum of 30% to 50% of the fee at the time of treatment. If your insurance payment is more or less, your account will be adjusted accordingly.

In the event that your Insurance Coverage, for whatever reason, denies and/or does not cover a procedure that Dr. Herbst deems necessary for your health and optimal care, you and/or your agent will be responsible to pay that fee(s).

If you do not have dental insurance or we are not a participant, your entire fee is due at the time of your treatment.

After 30 days, any unpaid balance would be subject to interest at the rate of 1.5% monthly ($5.00 minimum).

A $100.00 fee will be charged for broken appointments unless a 48 hour notification has been given.
There is a $35.00 fee for returned checks or stop payment checks.

The below signature also verifies patient receipt of the Notice of Privacy Practices.

Please list the family members or other persons, if any, whom we may inform about your dental condition and diagnosis (including treatment, payment and health care operations):

____

By receiving this Notice, as a patient in our office, you and your agent are made aware of and accept the terms listed above.
Patient Signature____Date___________________________
(Guardian Signature If Patient is a Minor)

If you have any questions regarding your treatment or fees, we will be happy to discuss them with you. Should you have any concerns between visits or after completion of your treatment, please do not hesitate to call.

In case of an Emergency Who May we Contact?

Emergency Contact: ___________________________Relationship_____________Phone_____________________

Today's Date **Patient's Name** **Birthdate**

___/___/_______ ____________________________________ ____/___/_____

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Dental History

How often do you brush?__________ How often do you floss?_____________
Do your gums bleed? ________ Have you ever had gum treatments? ___________
Do you grind, grit or clench your teeth? ___________________________________
Do you have any popping, clicking, or snapping noise when you chew? _________
Are you aware of any swelling, lumps, or sores in your mouth? ________________

Do you feel discomfort/pain when the tooth/teeth in question come in contact with:

Hot foods or liquids (soup, coffee, etc.)?	Yes☐	No☐
Cold foods or liquids (ice cream, cold water, etc.)?	Yes☐	No☐
Sweet or sour food (candy, oranges, fruit, etc.)?	Yes☐	No☐
When you bite down or chew?	Yes☐	No☐
Do any of the above symptoms linger for more than a minute or so?	Yes☐	No☐
Do symptoms wake you up from sleep?	Yes☐	No☐

Comments: ____

Health Questionnaire for Dental Evaluation and Treatment

Please circle Yes or No below. Your answers are confidential and necessary to treat you properly

YES NO 1. Are you in good health?
YES NO 2. Has there been any change in your general health in the past year?
Date of last checkup by a physician__________________________
YES NO 3. Are you currently under a physician's care?
If so, what for____
____
4. Treating Physician's Name__________________________________ Phone#____________
YES NO 5. Have you had any serious illness, operation or been hospitalized in the last five years?
If so, describe and give approximate dates_______________________________________
____

6. **Are you taking any of the following medications? If yes, which ones?**
YES NO Antibiotics?____
YES NO Blood Thinners/Aspirin Therapy?____
YES NO High Blood Pressure or Heart Medications?_____________________________________
YES NO Pain Medications?____
YES NO Others? (Please list all other current medications and vitamins)____________________
____

7. **Are you Allergic to or Had a Bad Reaction From**:
YES NO Local Anesthetic?
YES NO Penicillin, Amoxicillin, Cephalosporins?
YES NO Other Antibiotics? Which one?____
YES NO Barbiturates, sedatives?
YES NO Aspirin, Ibuprofen, NSAIDS, or other pain medication?
YES NO Codeine or other narcotics or opioids?
YES NO Latex?
YES NO Hay Fever
YES NO Other Allergies or reactions? Please list_______________________________________

____

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8. **Do you have or have you ever had:**

YES NO ***Cardiovascular disease*** (Chest Pain, Heart Trouble, Heart Attack, Coronary Artery Disease, High Blood Pressure, Palpitations, Heart Surgery, Angioplasty, Pacemaker)

YES NO ***Lung Disease*** (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, COPD, TB, Shortness of Breath, Severe Cough)

YES NO ***Neurologic Disorders*** (Seizure, Epilepsy, Fainting, Dizziness, Nervous Disorder)

YES NO ***Blood Disease*** (Bleeding Disorder, Anemia, Blood Transfusion, Do you bruise easily)

YES NO ***Liver Disease*** (Jaundice, Hepatitis)

YES NO ***Kidney Disease***

YES NO ***Diabetes*** (Type 1 or Type 2)

YES NO ***Thyroid Disease*** (Hypothyroidism, Tumor)

YES NO ***Arthritis*** (Which joint(s))____

YES NO ***Sarcoidosis***

YES NO ***Intestinal Problems*** (Stomach Ulcers, Gastric Reflux, Colitis)

YES NO ***HIV/AIDS***

YES NO ***Frequent or Recurring Mouth Sores***

YES NO ***Sexually Transmitted Disease***

YES NO ***Joint Replacement*** (Hip, Knee, Ankle, Wrist…)

YES NO ***Implants*** (Spine, Blood Vessel Patches, Repairs Aneurysm…)

YES NO ***Radiation* Therapy** (X-Ray treatment for Cancer in Head and Neck Region)

YES NO ***Fibromyalgia***

YES NO 9. Do you drink alcohol? How much per day? _______________________________
YES NO 10. Do you smoke? How much per day? ____________________________________
YES NO 11. Do you spit tobacco? How often? _______________________________________
YES NO 12. Are you, or have you been, in a drug or alcohol recovery program?
YES NO 13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? (Cancer, Benign Tumors, etc…)?

14. **WOMEN**
YES NO Are you taking Birth Control Pills?
YES NO Are you pregnant, trying to become pregnant or any chance you might be pregnant?
YES NO Are you Breast Feeding?
YES NO Are you taking Hormonal Replacement?

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

________________ ____
Date **Signature of person completing the Health History**

(Returning Patient) Medical History Update

Date	Changes	Patient Signature	Reviewed by