Jennifer E. Key, DMD
Practice Limited to Endodontics

Patient's Name: _____Date of Birth: _____/_____/_____
LAST FIRST MI

What do you prefer to be called: _____ MALE FEMALE SS #: _____-_____-_____

Home Address: _____City: _____Home Phone: (____)_____

State: _____ Zip: _____ Drivers License #: _____ Cell Phone: (____)_____

Employer: _____ Occupation: _____ Business Phone: (____)_____

Emergency Contact: _____ Relation: _____ Phone #: (____)_____

Referred By: _____ General Dentist: _____

Primary Dental Insurance: _____ Address: _____

Policy Holders Name: _____Relation: _____ Date of Birth: ____/_____/____

Insured's Employer: _____ Insured's SS #: _____ Group #: _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.
Initials I fully understand I am solely responsible for any balance not paid by my insurance company (if offered in this office).

Payment Method (please check one): ☐Cash ☐Check ☐MasterCard ☐Visa ☐Discover ☐Debit

Our Payment Policy

The usual and customary fee is determined by the number of canals involved and the degree of difficulty of treatment. ***Retreatment of previous root canal therapy and surgery are more complex and an additional fee will be charged for these procedures****. Payment is due at the time of treatment.* *******Your tooth will require a permanent restoration rendered by your general dentist, which is mandatory for the preservation of your tooth. This fee is not included in our service.*

Insurance: Please remember that your dental insurance is a contract between your employer and the insurance company. Professional services are performed and charged to the patient and not the insurance company.

Please complete back side

Jennifer E. Key, DMD
Practice Limited to Endodontics

MEDICAL HISTORY

Have you ever taken: Bisphosphonates (ex. Actonel/Fosamax) ___Yes ___NO or Phen-fen/Redux ___YES ___NO

Do you have or have you had any of the following diseases, medical conditions or procedures? (Please check if yes)

___Heart Attack/Stroke	___Thyroid Problems	___Cancer/Tumors	___Difficulty Breathing
___Heart Surgery/Pacemaker	___Kidney Problems	___Hepatitis	___Diabetes/Hypoglycemia
___Heart Murmur	___Liver Problems	___HIV+/AIDS/ARC	___Anemia
___Rheumatic Fever	___Respiratory Problems	___Arthritis/Rheumatism	___High/Low Blood Pressure
___Mitral Valve Prolapse	___Sinus Problems	___Artificial Bones/Joints	___Bleeding Problems
___Artificial Valves	___Stomach Problems/Ulcers	___Emphysema	___Blood Transfusion
___Heart Disease	___Psychiatric Problems	___Fainting/Seizures/Epilepsy	___Anticoagulants
___Congenital Heart Defect	___Scarlet Fever	___Severe/Frequent Headaches	___Steroid
___Chest Pains	___Venereal Disease	___Frequent Neck Pain	
___Nervousness	___Alcohol/Drug Abuse	___Back Problems	
___Tuberculosis TB	___Jaw Problems TMJ/TMD	___Asthma	

Please list any other surgeries or medical conditions you have ever had: _____
_____

Are you taking any medications? If yes, please list: _____
_____

Are you allergic to any of the following? __Latex __Penicillin/Amoxicillin __Tetracycline __Aspirin __Dental Anesthetics

Others (please list) _____

Women: Are you pregnant? __N __Y/How long? _____ Are you nursing? __No __Yes Birth control pills? __No __Yes

Do you use tobacco? __No __Yes/How used? _____ How much? _____ How Long? _____

Are you under the care of a physician? __N __Y If so, Physician's name and why _____

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient

- *Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made prior to.*
- *I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.*
- *By signing, you are stating that you have read and understand this form.*

Signature _____ ***Date*** ____/____/____

___Adult patient ___Parent or Guardian ___Spouse