MIDLANDS ENDODONTICS

MATTHEW D. EVANS, DMD
108 PALMETTO PARK BLVD., SUITE F
LEXINGTON, SC 29072
PHONE: 803-808-1110 ▪ FAX: 803-808-1188

PATIENT INFORMATION (Please Print)

Title:_____ First Name:_____ MI:_____ Last Name:_____

Soc.Sec.:_____ Gender: ◯Male ◯Female Birthdate: _____/_____/_____

Address:_____ Apt./Suite:_____

City:_____ State:_____ Zip code:_____

Mobile:_____ Home:_____ Work:_____

Email:_____

Referred By:_____ General Dentist:_____

PERSON RESPONSIBLE FOR ACCOUNT (**If other than patient**)

Title:_____ First Name:_____ MI:_____ Last Name:_____

Soc.Sec.:_____ Gender: ◯Male ◯Female Birthdate: _____/_____/_____

Address:_____ Apt./Suite:_____

City:_____ State:_____ Zip code:_____

Mobile:_____ Home:_____ Work:_____

Email:_____

DENTAL INSURANCE INFORMATION

PRIMARY

INS. Co._____

ID #._____

Group #._____

Employer:_____

Subscriber: ◯ Self / ◯ Other

(IF OTHER COMPLETE BELOW)

Name:_____

DOB: _____/_____/_____

SSN:_____

Sex: ◯ Male / ◯ Female

DENTAL INSURANCE INFORMATION

SECONDARY

INS. Co._____

ID #._____

Group #._____

Employer:_____

Subscriber: ◯ Self / ◯ Other

(IF OTHER COMPLETE BELOW)

Name:_____

DOB: _____/_____/_____

SSN:_____

Sex: ◯ Male / ◯ Female

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed PLUS $50 collections fee on any balance due, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

I also acknowledge that I will be charged a cancellation fee if I should fail, reschedule, or cancel an appointment without 24 hours notice.

_____ _____

Signature (parent/guardian) **Date** Midlands Endodontics STAFF

Dental and Medical History

Patient Name (Please Print): _____

Emergency Contact: _____ **Phone:** _____

Yes / No Are you currently undergoing medical treatment of any kind? If so, please describe _____

_____

Name of Physician: _____ Phone #: _____

Name of Pharmacy: _____ Phone #: _____

Yes / No Are you allergic (hives/swelling) to any drugs? If so, what? _____

Yes / No Are you allergic to **latex**?

Yes / No Do you smoke or use smokeless tobacco? If so, how often? _____

Yes / No Do you use alcohol and/or recreational drugs? If so, how often? _____

Yes / No Do you take medication to **aid in sleep**? If so, what? _____

Yes / No Are you currently taking **any blood thinners**? If so, what? _____

Yes / No Have you ever taken medication for Osteoporosis? If so, what AND when? _____

Yes / No Are you **pregnant**? Due Date _____

Yes / No Do you take **PREMED** prior to **EVERY** dental visit?

Yes / No Have your teeth been difficult to numb in the past?

Yes / No Have you had any problems with previous dental treatment? If so, what? _____

Yes / No **Do you have dental anxiety or nervousness?**

Yes / No Do you have sleep apnea? Yes / No Do you use a CPAP?

Have you had or have the following (**please circle**):

AIDs/HIV	Epilepsy	Herpes	Seasonal Allergies
Arthritis	GERD	Joint Replacement, when? _____	Sinus Problems
Asthma	High Blood Pressure	Kidney Problems	Thyroid Problems
Cancer, type: _____	Heart Problems	Radiation Therapy	Tuberculosis
Cortisone Therapy	Heart Murmur	Rheumatic Fever	Ulcer / Colitis
Diabetes	Hepatitis	Scarlet Fever	

Please list ALL medications that you are currently taking, including vitamins and herbs

_____

_____

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____

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PATIENT FINANCIAL RESPONSIBILITY

- We accept cash, Visa, Mastercard, Discover card, American Express and CareCredit. We **do not** offer in-house or office financing. Patient payment plans are available through CareCredit (1-800-859-9975) or www.carecredit.com. **Payment is expected at the time of treatment.**

- **Midlands Endodontics charges $30.00 for all returned checks.** Further action will be taken to collect any debts owed.

- As a **courtesy** we are happy to assist you in filing of your dental insurance claims if you provide the requested information. Insurance contracts are between you and your insurance company; and depending on our contract with the insurance company we may/may not be in-network. Depending on the contract any charges **not covered** or paid by your insurance company is your responsibility.

- Any fees **estimated** by your insurance company to be patients responsibility **will be collected at time of service.**

- If benefits are assigned to our office, we will wait a maximum of sixty (60) days for payment from the insurance company. If payment is not received the balance will be your responsibility.

- I authorize the release of any information pertinent to my case to any insurance company, adjuster, dentist, physician or attorney in the case. I also authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand that I am responsible for any authorize payment of all fees (to include legal and a collection fee of $50) regardless of my insurance benefits. Outstanding balances may be collected by check, credit card or any other legal means.

Signature_____ Date:_____

I hereby instruct and direct my insurance company to pay by check made out to Midlands Endodontics, LLC OR Matthew D. Evans, DMD and mailed to : 108 Palmetto Park Blvd., Suite F, Lexington, SC 29072 for benefits allowable and otherwise payable to me my current insurance policy as payment toward the total charges for the service rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of the assignment shall be considered as effective and valid as the original

Signature_____ Date:_____

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Matthew D. Evans, DMD

Consent Form of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing the consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a copy by submitting your request in writing to our office manager.

You have the right to request that we restrict how protected health information about you is used to disclose for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by your agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

_____ _____
Patient/Guardian Signature Date

_____
Printed Name of Patient/Guardian

Please list the name(s) of any person(s) that you would like to allow your information to be released to (excluding your general dentist)

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number