



Patient Name  Ms.  Mrs.  Mr.  Dr. \_\_\_\_\_ Birthday \_\_\_\_ / \_\_\_\_ / \_\_\_\_

How would you like to be addressed? \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City / State / Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

City / State / Zip \_\_\_\_\_

Who Referred You to this Office? \_\_\_\_\_

Family Dentist \_\_\_\_\_ Patient's SS# \_\_\_\_\_

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**PRIMARY DENTAL INSURANCE**

Subscriber Name \_\_\_\_\_

Subscriber's SS# or ID# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Group# \_\_\_\_\_

Name & Address of Primary Dental Insurance Co. \_\_\_\_\_

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**SECONDARY DENTAL INSURANCE**

Subscriber Name \_\_\_\_\_

Subscriber's SS# or ID# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Group# \_\_\_\_\_

Name & Address of Secondary Dental Insurance Co. \_\_\_\_\_

**AUTHORIZATION FOR INFORMATION AND INSURANCE RELEASE**

I authorize release of information to my family dentist and to my insurance company(s) in order to process my insurance claim. I understand that I am responsible for all costs of my dental treatment. I understand that this endodontic specialty practice is a participating provider with Delta Dental Premier and no other insurance plans and that I am responsible for knowing the terms of my own insurance coverage. If fees are not paid in full by me at the time of service, I hereby authorize payment of dental benefits from insurance, otherwise payable to me, directly to James R. Murrin, DDS, MS, Inc.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signed (Employee or Spouse, Parent if minor) \_\_\_\_\_ Date

**Have you had, or do you presently have any of the following conditions?**

	Yes	No		Yes	No
Heart Attack - Date _____	<input type="radio"/>	<input type="radio"/>	Jaw Joint (TMJ) Problems.....	<input type="radio"/>	<input type="radio"/>
Stroke - Date _____	<input type="radio"/>	<input type="radio"/>	Ulcers .....	<input type="radio"/>	<input type="radio"/>
Heart Surgery - Date _____	<input type="radio"/>	<input type="radio"/>	Colitis or Irritable Bowel Syndrome.....	<input type="radio"/>	<input type="radio"/>
Heart Disease.....	<input type="radio"/>	<input type="radio"/>	Surgery or x-ray treatment for a tumor, growth, or other condition of the head, mouth, or lips.....	<input type="radio"/>	<input type="radio"/>
Aortic Stenosis.....	<input type="radio"/>	<input type="radio"/>	AIDS or HIV Positive .....	<input type="radio"/>	<input type="radio"/>
Bacterial Endocarditis.....	<input type="radio"/>	<input type="radio"/>	Hepatitis, Jaundice, or Liver Disease .....	<input type="radio"/>	<input type="radio"/>
Artificial Vascular Graft .....	<input type="radio"/>	<input type="radio"/>	Blood Transfusion .....	<input type="radio"/>	<input type="radio"/>
Chest Pain/Angina Pectoris.....	<input type="radio"/>	<input type="radio"/>	Drug Addiction/Alcoholism.....	<input type="radio"/>	<input type="radio"/>
High/Low Blood Pressure.....	<input type="radio"/>	<input type="radio"/>	Hemophilia or Excessive Bleeding .....	<input type="radio"/>	<input type="radio"/>
Heart Murmur .....	<input type="radio"/>	<input type="radio"/>	Cold Sores/Herpes .....	<input type="radio"/>	<input type="radio"/>
Rheumatic Fever/Rheumatic Heart Disease .....	<input type="radio"/>	<input type="radio"/>	Glaucoma .....	<input type="radio"/>	<input type="radio"/>
Congenital Heart Lesions/Mitral Valve Prolapse....	<input type="radio"/>	<input type="radio"/>	Depression/Psychiatric Treatment.....	<input type="radio"/>	<input type="radio"/>
Artificial Heart Valve - Date _____	<input type="radio"/>	<input type="radio"/>	Allergies/Hay Fever.....	<input type="radio"/>	<input type="radio"/>
Heart Pacemaker .....	<input type="radio"/>	<input type="radio"/>	Asthma.....	<input type="radio"/>	<input type="radio"/>
Joint Replacement - Site _____ Date _____	<input type="radio"/>	<input type="radio"/>	Sinus Trouble .....	<input type="radio"/>	<input type="radio"/>
Kidney Disease.....	<input type="radio"/>	<input type="radio"/>	Seizures/Epilepsy .....	<input type="radio"/>	<input type="radio"/>
Cancer or Tumors.....	<input type="radio"/>	<input type="radio"/>	Arthritis .....	<input type="radio"/>	<input type="radio"/>
Thyroid Disease.....	<input type="radio"/>	<input type="radio"/>	Phen-Fen or Redux Diet .....	<input type="radio"/>	<input type="radio"/>
Lung Disease/Tuberculosis.....	<input type="radio"/>	<input type="radio"/>			
Diabetes.....	<input type="radio"/>	<input type="radio"/>			

Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel, Boniva, Evista, Fosamax, or Zometa?  Yes  No

Are you currently taking prescription blood thinner (Coumadin or Warfarin)? Most recent INR value \_\_\_\_\_ date \_\_\_\_\_.

Are you currently a smoker or using tobacco products?  Yes  No

**Have you ever had an allergic or unusual reaction to any of the following?**

	Yes	No		Yes	No
Local Anesthetics ("Novocaine").....	<input type="radio"/>	<input type="radio"/>	Penicillin or Amoxicillin .....	<input type="radio"/>	<input type="radio"/>
Ibuprofen or Advil.....	<input type="radio"/>	<input type="radio"/>	Clindamycin or Other Antibiotics .....	<input type="radio"/>	<input type="radio"/>
Acetaminophen (Tylenol).....	<input type="radio"/>	<input type="radio"/>	Triazolam, Halcion or Valium .....	<input type="radio"/>	<input type="radio"/>
Barbiturates/Tranquilizers (Sleeping Pills).....	<input type="radio"/>	<input type="radio"/>	Any Other Medication or Drugs.....	<input type="radio"/>	<input type="radio"/>
Codeine or Other Narcotics.....	<input type="radio"/>	<input type="radio"/>	Which Ones? _____		
Latex/Rubber Materials.....	<input type="radio"/>	<input type="radio"/>	_____		
			_____		

**Women:**

	Yes	No	
Are You Pregnant? .....	<input type="radio"/>	<input type="radio"/>	If Yes, How Many Months? _____
Do You Anticipate Becoming Pregnant?.....	<input type="radio"/>	<input type="radio"/>	
Are You Breast Feeding? .....	<input type="radio"/>	<input type="radio"/>	

**Please list any medications and/or recreational drugs (over the counter, prescription, or herbal/alternative) that you are taking now:**

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**If you have had any serious complications involving dental treatment, please explain:**

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**Informed Consent:** I understand that root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Occasionally, a patient may experience post-operative discomfort or swelling which may require medication for several days. Although root canal therapy 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 root canal therapy may require retreatment, surgery, or even extraction.

\_\_\_\_\_  
Patient (or Guardian) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Updates