Annapolis Endodontics

Board Certified Endodontists
200 Westgate Circle -- Suite 104
Annapolis, MD 21401
410-268-4770

Louis H. Berman, D.D.S.
Mark D. Lentz, D.M.D.
Kenneth R. Hunter, D.D.S.

Patient Registration

Your Name (first name) _____ (middle init)_____ (last name)_____

Address _____

City _____State _____ Zip_____

Date of Birth _____ Female ❑ Male ❑

Social Security Number _____ General Dentist _____

Home Telephone _____ Referred By _____

Employer / School _____ Work Telephone _____

Spouse's Name _____ Occupation _____

Dental Insurance

Who is responsible for this account: _____

Company Name _____ Employer _____

Policy Holder _____ Employer's Address _____

Date of Birth _____ Work Telephone _____

Membership Number _____ Social Security Number_____

Group Number _____ Date of Birth _____

Medical History

Name of your physician _____

Do you require antibiotics before dental treatment? Yes ❑ No ❑ If yes, give reason below.

Have you been hospitalized in the last 5 years? Yes ❑ No ❑ If yes, for what?_____

Please list medications you are taking _____

_____

Do you have, or have you had, any of the following? Indicate "yes" with a ☑

- ❑ Allergies (list below)
- ❑ Heart disease (angina, heart attack, bypass)
- ❑ Pacemaker or artificial valve
- ❑ Rheumatic fever
- ❑ High blood pressure
- ❑ Shortness of breath
- ❑ AIDS, HIV, or high risk
- ❑ Lung disease or Tuberculosis
- ❑ Blood disorder (describe below)
- ❑ Excessive bleeding from cut or extraction
- ❑ Malignancies/ cancer
- ❑ Radiation or chemotherapy treatment
- ❑ Thyroid or parathyroid condition
- ❑ Hepatitis/liver problems
- ❑ Diabetes
- ❑ Excessive thirst/urination
- ❑ Stroke
- ❑ Hip or joint replacement
- ❑ Sinus problems
- ❑ Glaucoma
- ❑ Ulcer, Colitis, or G.I. problems
- ❑ (Women) Are you pregnant
- ❑ Kidney disorder

❑ Other: Please explain_____

❑ Allergies to medications (for example, Penicillin or "Novocain") _____

Comments: _____

Dental History

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

Hot foods or liquids (soups, 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 ☐

Comments: _____

_____

_____

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. In the event of non-healing, the patient is still financially responsible for treatment. Occasionally a tooth which has had endodontic treatment may require retreatment, surgery, or even extraction, any of which, and any subsequent treatment, will be the financial responsibility of the patient. Additionally, during the course of treatment, the crown, porcelain or restoration may be damaged or require replacement, which shall be the sole financial responsibility of the patient.

When your treatment is completed, your tooth will need a final restoration (filling, cap, 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 shortly after treatment is complete.

PAYMENT: It is expected that payment for all treatment be made in full upon completion of treatment.

DENTAL INSURANCE: As a convenience to you, our office will fill out the necessary forms and submit them to your insurance company. However, *we consider each patient responsible for their entire account.* As most insurance companies provide coverage from 50% to 80%, we require *a minimum of 30%* of the fee prior to the completion of your treatment. If your insurance payment is more or less, your account will be adjusted accordingly. All accounts that are more than 60 days overdue will be assessed a finance charge of 15% A.P.R. The signature below verifies patient receipt of Notice of Privacy Practices.

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.

PATIENT'S SIGNATURE: _____ DATE: _____