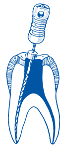

Dr. Kent A. Spriggs, D.D.S., M.S., P.C.

ENDODONTICS

(PLEASE PRINT LEGIBLY) Age ________ Birthdate ____________ ☐ M ☐ F SSN# ____________________
(For accounting purposes only)

Last Name ______________________________ First ______________________________

Address ______________________ City ________________ State ________ Zip ________

Home Phone ________________ Work Phone ________________ Cell Phone ________________

Employer ________________ In case of emergency (person to call) __________ Phone(s) __________

General Dentist ______________________________

ARE YOU COVERED BY DENTAL INSURANCE? ☐ Yes ☐ No

Insurance Company Name ____

Address ______________________ Phone ______________ Group ID# ______________

Policy Holder's Name ____________ SSN# ________ Insurance ID# __________ D.O.B. __________

Employer ______________________________ Relationship to Patient ____________________

ARE YOU COVERED BY A SECOND DENTAL INSURANCE (i.e. through a spouse)? ☐ Yes ☐ No

Insurance Company Name ____

Address ______________________ Phone ______________ Group ID# ______________

Policy Holder's Name ____________ SSN# ________ Insurance ID# __________ D.O.B. __________

Employer ______________________________ Relationship to Patient ____________________

METHOD OF PAYMENT

(Please indicate which method you will be using today)

BCBS, Metlife or Delta Dental Insurance $250 payment ____________ **All others, Payment in Full** ____________

with: Cash ________ **Check** ________ **Credit Card** ________

If payment is not possible today, please speak to receptionist prior to your appointment.

Treatment Fees and Payment of Accounts

(Read carefully prior to treatment)

____________________	Office Visit: $70-$150	____________________
____________________	Anterior teeth: $700-$1,100	____________________
____________________	Bicuspid Teeth: $800-$1,200	____________________
____________________	Molar teeth: $1,100-$1,400	____________________
____________________	Surgery: (per tooth): $800-$1,500	____________________
____________________	Access foundation: $100-$250	____________________
____________________	Other: (______________)	____________________
____________________	Total:	____________________

I have read the above and understand my financial obligation. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Signature: ______________________________ Date: ______________________________

PLEASE MAKE A CHECK IN THE SPACE PROVIDED IF YOU HAVE NOW, OR HAVE EVER HAD ANY OF THE FOLLOWING CONDITIONS:

- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Hepatitis (non-A, non-B)
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ Cancer
- ☐ Chest pain upon exertion
- ☐ Heart murmur
- ☐ Artificial heart valve
- ☐ Heart trouble
- ☐ Heart disease or attack
- ☐ Angina
- ☐ Heart pacemaker
- ☐ Stroke
- ☐ Congenital heart lesions
- ☐ Heart surgery
- ☐ Mitral valve prolapse
- ☐ Allergies or hives
- ☐ Hay Fever
- ☐ Tuberculosis
- ☐ Hx of Chemical Dependency
- ☐ Recent illness
- ☐ Infectious mononucleosis
- ☐ Frequent swollen ankles
- ☐ Liver Disease
- ☐ Arthritis
- ☐ Yellow jaundice
- ☐ Rheumatism
- ☐ Hemophilia
- ☐ Sickle cell anemia
- ☐ Thyroid disease
- ☐ Rheumatic fever
- ☐ Glaucoma
- ☐ Fainting or dizzy spells
- ☐ Glandular disease
- ☐ Artificial joints
- ☐ Nose obstruction
- ☐ Prostatitis
- ☐ Anemia
- ☐ Kidney dialysis
- ☐ Diabetes
- ☐ Sinus trouble
- ☐ Emphysema
- ☐ Cortisone medication
- ☐ Blood transfusion
- ☐ Bleeding tendency
- ☐ Asthma
- ☐ High/low blood pressure
- ☐ Kidney trouble
- ☐ Pain in the jaw joints
- ☐ Scarlet fever
- ☐ Ulcers/colitis
- ☐ Epilepsy
- ☐ Bronchitis
- ☐ Lung disease
- ☐ Recent cough or cold
- ☐ Blood disease
- ☐ AIDS, ARC, HIV
- ☐ STD’s
- ☐ Cold sores
- ☐ Pregnant - currently weeks ___________
- ☐ Other ____

Have you been hospitalized in the past 5 years? ☐ **Yes** ☐ **No** **(If yes, why, when?)**

____

____

Please list all Prescription medications.

____

____

____

Are you allergic to any medicines? ☐ **Yes** ☐ **No** **(If yes, which?)**

____

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

Do you premedicate with antibiotics prior to dental treatment? ☐ **Yes** ☐ **No**
(Due to heart diagnosed murmur or joint (i.e. hip, knee) replacement)

Have you consumed alcohol or other drugs to relax you for this appointment (legal or otherwise)? ☐ **Yes** ☐ **No** **(If yes, what, when?)**

____

____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

I, ______________________________ , have received a copy of this office’s Notice of Privacy Practices.

Signature: ______________________________ Date: ______________________________