D. Wayne Hughart, DDS, MS

Practice Limited To Endodontics

109 Fox Road
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PERSONAL INFORMATION:

Name: _____

Nickname: _____

Address: _____ City: _____ State: _____ Zip: ____

Home Phone: _____ Work Phone: _____ Sex: _____

Birthdate: _____ Social Security #: _____

Occupation _____ Employer: _____

Employer's Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

DENTAL INSURANCE INFORMATION:

Policy Holder's Name: _____ Relationship: _____

Birthdate: _____ Social Security #: _____

Employer: _____ Work Phone: _____

Insurance Company: _____ Group #: _____

ADDITIONAL DENTAL INSURANCE:

Policy Holder's Name: _____ Relationship: _____

Birthdate: _____ Social Security #: _____

Employer: _____ Work Phone: _____

Insurance Company: _____ Group #: _____

MEDICAL HISTORY:

Please check all that apply & any conditions not listed:

- ❑ Arthritis
- ❑ Hepatitis or Jaundice
- ❑ Liver Disease
- ❑ Epilepsy
- ❑ Thyroid Disease
- ❑ Glaucoma
- ❑ Radiation Treatment
- ❑ Lung Disease
- ❑ Cold Sores
- ❑ Hiv or Aids
- ❑ Sinus Trouble
- ❑ Prolonged Bleeding
- ❑ Fainting Tendency
- ❑ High/Low Blood Pressure
- ❑ Chest Pain
- ❑ Stroke
- ❑ Shortness of Breath
- ❑ Asthma or Hayfever
- ❑ TMJ/Clicking Joint
- ❑ Blood Disease
- ❑ Heart Trouble/Surgery
- ❑ Cancer or Tumor
- ❑ Tuberculosis
- ❑ Diabetes
- ❑ Kidney/Bladder Trouble
- ❑ Anemia
- ❑ Psychiatric Problem_____
- ❑ Prosthetic Joint Replacement
  When? _____
- ❑ Other _____

Some medical conditions require medication prior to treatment. It may be necessary to reschedule your appointment to ensure your safety.

Do you have an allergy or intolerance to any of the following?

- ❑ Penicillin
- ❑ Codeine
- ❑ Sulfa
- ❑ Aspirin
- ❑ Latex
- ❑ Other _____

Please turn over ➥

Patient information:

Continued:

Please list current medication & supplements: _____

_____

_____

_____

_____

_____

_____

Have you ever had an epinephrine reaction during dental treatment? ❑ Yes ❑ No

Are you pregnant?_____If yes, how many months?_____Are you breastfeeding?_____

Who is your general dentist? _____Phone #:_____

Financial arrangements:

Estimated fees for primary services are listed below.

Additional charges may apply.

Examination: $100.00	Pulp test:..... $ 30.00
Anterior:..... $920.00	Retreat anterior: $1210.00
Bicuspid: $1020.00	Retreat bicuspid:..... $1320.00
Molar: $1220.00	Retreat molar:..... $1530.00

For your convenience we offer the following methods of payment. Please check the option you prefer

❑ Cash ❑ Check ❑ Credit Card ❑ Care Credit Healthcare Financing

We file all insurance.

Fees are due when services are rendered.

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for any balance for services rendered regardless of insurance coverage for said treatment.

In accordance with the terms of the contract, if the account is not paid within 30 days after the services are rendered, the account shall be subject to a service charge of 1 1/2% per month which shall be compounded.

In the event that the account, including any service charge is placed in the hands of a collection agency or attorney, the patient/guarantor agrees to pay an additional 50% of the balance due towards collection costs, including attorney's fee and court costs.

I authorize the dentist to utilize my x-rays and case history for professional presentations, Articles, or clinics.

I have read and agree to the foregoing conditions, and, to the best of my knowledge, all of the preceding answers are correct.

Patient/Guardian signature _____ Date_____