

**Welcome to  
Cameo Endodontics, Ltd.**

Please Complete Both Sides

**Patient Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Please check one:  Single  Married  Widowed  Divorced  Separated

Address \_\_\_\_\_

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

Home Telephone \_(\_\_\_\_)\_\_\_\_\_ Work Telephone \_(\_\_\_\_)\_\_\_\_\_

Cell Phone \_(\_\_\_\_)\_\_\_\_\_ Best place to reach you \_\_\_\_\_

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

Business Address \_\_\_\_\_

Referring/General Dentist \_\_\_\_\_

**Primary Dental Insurance Information**

Insurance Company Name \_\_\_\_\_

Insurance Address \_\_\_\_\_

Telephone \_(\_\_\_\_)\_\_\_\_\_ Group Number \_\_\_\_\_

Name of Insured \_\_\_\_\_ Social Security \_\_\_\_\_

Insured DOB \_\_\_\_\_ Employer \_\_\_\_\_

**Secondary Dental Insurance Information**

Insurance Company Name \_\_\_\_\_

Insurance Address \_\_\_\_\_

Telephone \_(\_\_\_\_)\_\_\_\_\_ Group Number \_\_\_\_\_

Name of Insured \_\_\_\_\_ Social Security \_\_\_\_\_

Insured DOB \_\_\_\_\_ Employer \_\_\_\_\_

**If a Minor (under age 21)**

Parents Name \_\_\_\_\_ Social Security \_\_\_\_\_

Home Telephone \_(\_\_\_\_)\_\_\_\_\_ Work Telephone \_(\_\_\_\_)\_\_\_\_\_

# Medical Information

Have you ever had (Please Circle Yes or No)

Heart Trouble .....	Yes	No	Rheumatic Fever .....	Yes	No
Convulsions .....	Yes	No	Asthma .....	Yes	No
High Blood Pressure .....	Yes	No	Thyroid Problems .....	Yes	No
Nervous Disorders .....	Yes	No	Anemia .....	Yes	No
Bleeding Problems .....	Yes	No	Hepatitis .....	Yes	No
Diabetes .....	Yes	No	HIV+ .....	Yes	No

Are you currently taking or have taken bisphosphonate medications, such as Actonel, Fosamax or Zometa, within the past twelve years?.....Yes No

Have you had a hip, joint, or valve replacement?.....Yes No  
If so, when? \_\_\_\_\_

Does your physician tell you to premedicate with an antibiotic before dental appointments for any medical condition? ..... Yes No

Have you ever taken any medicines for your heart or high blood pressure? ..... Yes No

Are you now taking any kind of medicine, drug, alcohol or pills for any purpose? ..... Yes No  
If so, what? \_\_\_\_\_

Are you allergic to any food, medicine, or drug? ..... Yes No  
If so, what? \_\_\_\_\_

Are you allergic to local anesthetic? ..... Yes No

Are you allergic to latex?.....Yes No

Have you been under the care of a physician during the last year? .....Yes No  
Name of Physician \_\_\_\_\_

Is there any condition concerning your health the doctor should be told?..... Yes No  
If so, what? \_\_\_\_\_

Have you ever had Root Canal Therapy before? ..... Yes No

Women Are you pregnant or breast feeding? ..... Yes No

I certify that these statements concerning my health are correct to the best of my knowledge.

Date \_\_\_\_\_ Signed \_\_\_\_\_

### Our Usual Fees

Anterior (front teeth).....\$790.00 and up  
Bicuspids (middle teeth) ..... \$895.00 and up  
Molars (back teeth)..... \$1040.00 and up  
Consultation ..... \$95.00  
Retreatments: Additional Fee

The above fees do not include the final restoration by your general dentist. You will leave our office with a temporary filling after the root canal therapy. You are responsible to follow-up with your dentist after treatment is completed in our office. There is a \$45.00 charge for all missed appointments.

### Our Financial Policy

#### With Insurance

We will gladly bill your dental insurance company for any charges incurred in our office. We do require those with insurance to provide us with sufficient information to bill your insurance company. Any benefit information we obtain from your insurance company is an estimate and only done as a courtesy. You are ultimately responsible for any balance on your account. We require you to pay your estimated portion the day services are rendered. We will send you a statement or refund once the insurance has paid if there is any difference.

#### Self-Pay

We ask that the services provided are paid in full by the time they are completed. If two visits are required 50% is due today and the remainder at the following visit.

#### All patients please read and sign the following:

I have read and understand the above policies. I authorize the release of any information to my insurance company pertaining to any services rendered. I also authorize payment to be made directly to the dentist. I am aware that any unpaid balance after work is completed is subject to an 18% finance charge. Any collections fees for delinquent accounts is the responsibility of the patient, fees equal 1/3 of balance.

Date \_\_\_\_\_ Signed \_\_\_\_\_

#### Payment Option

We offer the option to leave your credit card number on file. We will then bill your insurance and apply any balance to your card after they have paid. If interested please fill out the following.

Visa     Mastercard     Discover     American Express

Card Number:                 Exp   /   signature code \_\_\_\_\_

I authorize Cameo Endodontics to charge my credit card for the balance on my account.

Signature \_\_\_\_\_ Date \_\_\_\_\_