

Adnan Kazim , DMD
Endo Excellence

Date _____

Patient Information
(Please complete all parts of this form)

Name _____
Last First Middle Marital status
Residence _____
Street City State Zip
Social Security Number _____ Birthdate ____/____/____
Home telephone number _____ Dentist _____
Cell telephone number _____ Work telephone number _____
Occupation _____
Relationship to Insured _____ Email address _____
Pharmacy number _____ Emergency contact name/number _____

Dental Insurance Information

Subscriber's Name _____ Subscriber's DOB ____/____/____
Employer _____ Subscriber's SS# _____
Employer's Address _____ ID No _____
Insurance Company _____ Group No _____
Insurance Co Address _____ Ph # () _____

Do you have secondary dental coverage? Yes__ No__ If yes: **Please complete the following secondary insurance information.**

Subscriber's Name _____ Subscriber's DOB ____/____/____
Employer _____ Subscriber's SS# _____
Employer's Address _____ ID No _____
Insurance Company _____ Group No _____
Insurance Co Address _____ Ph # () _____

Authorization to Release Information

I hereby authorize the above named dentist(s) to provide any insurance company(s), claim Administrator(s), and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

Patient or Authorized Guardian's Signature

____/____/____
Date

Health History

1. Do you have or have you had any of the following? (please circle)

- | | |
|--|---|
| a. Rheumatic fever | i. Hepatitis, jaundice or liver disease |
| b. Congenital heart disease | j. Stomach ulcers |
| c. Cardiovascular: heart attack, coronary insufficiency, high blood pressure, arteriosclerosis, stroke, coronary bypass, and prosthetic valve. | k. Kidney trouble |
| d. Abnormal bleeding | l. Tuberculosis, lung disease |
| e. Asthma, hay fever, sinus trouble | m. Fainting spells, seizures or epilepsy |
| f. Hives or a skin rash | n. Temporomandibular joint problems |
| g. Venereal disease | o. Psychiatric treatment |
| h. Diabetes | p. Acquired immune deficiency syndrome (AIDS) |
| Other: _____ | q. Joint Prosthesis (hip, etc.) |
| | r. PACEMAKER |

2. Are you allergic to penicillin, local anesthetics, pain killers or any drugs:

If so, which drugs: _____

3. Has there been any change in your general health within the past year: Yes__ No__

4. Are you now under the care of a physician: _____ Yes__ No__

Nature of treatment: _____

5. Do you have a heart murmur? _____ Yes__ No__

6. For Medical Reasons, are you required to take antibiotics prior to dental treatment? _____ Yes__ No__

7. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? _____ Yes__ No__

8. Have you ever had surgery and/or radiation or chemotherapy for tumor or growth _____ Yes__ No__

9. Are you taking any medications? If so, name them: _____

10. Do you have any disease, conditions or problems not list above? _____ Yes__ No__

11. Date of last physical exam _____

12. (Women) Are you pregnant? Yes__ No__ If Yes, are you breastfeeding? Yes__ No__

INFORMED CONSENT

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by any of the endodontists employed by or associated with Adnan Kazim D.M.D and any assistant that may be required. I agree to the use of local anesthesia, sedation, and/or analgesia, depending upon the judgement of the endodontist involved in my case. Complications of root canal therapy and anesthesia may include swelling, discomfort, infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum or tongue, which rarely is protracted and even more rarely is permanent.

I understand that root canal therapy is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, results cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require treatment, surgery, or even extractions. I also understand that only the root canal therapy is to be performed at this office; restoration of my tooth (filling, crown, etc.) will be done by my family dentist. During treatment, there is the possibility of instrument breakage within the root canals, perforations (extra openings), damage to bridges, existing filling, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when my tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definitive symptoms to develop or tooth extractions. Risks involved in these choices might include but are not limited to pain, infection, swelling, loss of teeth, and infection to other areas.

I understand that medications for discomfort and sedations may cause drowsiness which can be increased by the use of alcohol or other drugs. I will avoid operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call my doctor immediately. I understand that it is my responsibility to report any changes in my medical history.

All responsible collection and/or legal costs required to collect fees due Adnan Kazim, D..M.D, Endo Excellence, will be borne by the undersigned.

ALL SIGNATURES MUST BE BY PARENT OR GUARDIAN IS PATIENT IS 18 YEARS OR YOUNGER.

DATE

SIGNATURE

Adnan Kazim D.M.D.
Endo Excellence
509 S. Lenola Rd. Ste 3A
Moorestown, NJ 08057
Patient Financial Responsibility Form

Thank you for choosing Dr. Adnan Kazim & Associates for your endodontic care. As a courtesy to you, if you have dental insurance, we will file a claim with your insurance company. Your co-pay responsibility is based on your dental plan policy. **You are responsible for your co-pay portion at time of service.** The out of pocket cost given to you is just an estimate. If your insurance becomes maxed out prior to receiving our claim it may drastically affect your out of pocket cost. If after insurance pays and you have a remaining balance that insurance did not cover, you will be sent a statement and are responsible for any remaining amount insurance may not cover.

If you do not have dental insurance, full amount of fee is due at time of service unless other arrangements have been made by the front staff. In the event there is an overpayment by you, our office will submit a refund due to you. Refunds are not given until your insurance company has paid.

You are responsible for any collection, legal costs, finance charges or any other fees associated with the collection process.

We gladly accept all major credit cards, cash, checks, or Care Credit. Should you have any questions about the financial policy, feel free to ask the front desk.

I have read the above information and I understand that I am fully responsible for any balance remaining after my insurance has settle my claim with your office.

Signature _____ Date _____

**Adnan Kazim D.M.D.
509 S. Lenola Rd. Ste 3A
Moorestown, NJ 08057**

In New Jersey insurance companies are required by law to settle claims within 30 days. We send your claims out the day of service. If your claim is not paid by your insurance company in 45 days, you will be personally responsible.

You can negotiate with your insurance company. If any payment is made to us after having received payment, any credit due you will be issued immediately.

Thank you for your kind attention in this matter.

Signature

Date