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

   Other: _____

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 Sara Fonseca, D.D.S. 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 Sara Fonseca, D.D.S. will be borne by the undersigned.

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

_____ _____

DATE *SIGNATURE*

Sara Fonseca D.D. S.
509 S. Lenola Rd. Ste 3A
Moorestown, NJ 08057

Patient Financial Responsibility Form

Thank you for choosing Dr. Sara Fonseca 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_____

Sara Fonseca D.D. S.
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

How did you hear about our office?

Dentist___ Google___ Facebook___ Patient___ Other (Explain)_____

(name of patient if referred by patient)_____

Here at Endo Excellence we are a social practice and we love to share fun moments around the office on social media. If you would like to be a part of the social media fun, read and sign the consent form below.

I consent that Endo Excellence may use photographs or videos taken of me, taken on the date indicated below, on their social media tools.

Name (print):

Signature:

Date:

_____

For Minors:

Name of Minor (print):

Name of Legal Guardian (print):

Signature:

Date:

_____

Decline___