Tod T. Bruchmiller, D.D.S., M.S., P.A. | Joshua C. Gorman, D.D.S., M.S.
Practice Limited to Endodontics

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. Let us know if we can be of any assistance. We look forward to working with you.

Patient Information

Name: Soc. Sec. #

First Name / Middle Initial / Last Name

Address: Drivers Lic. #

City: State: Zip: Home Phone:

Sex: M F Birth Date: Marital Status:

Patient Employed by: Work Phone:

Whom may we thank for referring you?

Notify in case of emergency:

Emergency Contact Home Phone: Work Phone:

Primary Dental Insurance

Person Responsible for Account:

First Name / Middle Initial / Last Name

Primary Insurance ID# Soc. Sec. #

Birth Date: Relation to Patient:

Address (if different from patient) :

Home Phone: Work Phone:

Person Responsible Employed by: Occupation:

Business Address:

Insurance Company: Phone # Group #

Is patient covered by additional insurance? Yes No If yes, please notify our office personnel.

Insurance Co. Address:

If Double Coverage Applies:

Employee Name:

Soc. Sec. No. of Employee: Birth Date of Employee:

Employer:

Secondary Carrier Name: Policy/Group #

Secondary Carrier Address: Phone #

Medical History

Physician's Name: City: Phone:

Date of last visit: Purpose of visit:

Have you been a patient in the hospital during the past two years? Yes No

Reason:

Have you been under the care of a medical doctor during the past two years? Yes No

Reason:

Do you feel nervous about having dental treatment? Yes No

Have you ever had a bad experience in a dental office? Yes No

Have you ever had any of the following?

AIDS/HIV Positive
Anaphylaxis
Anemia
Arthritis rheumatism
Artificial heart valves
Artificial joints
Asthma
Atopic (allergy prone)
Back problems
Blood disease
Bruise easily
Cancer
Chemical dependency
Chemotherapy
Circulatory problems

Cortisone treatments
Cough, persistent or bloody
Diabetes
Epilepsy
Fainting
Food allergies
Glaucoma
Headaches
Heart murmur
Heart problems (specify below)
Hemophilia
Abnormal bleeding
Hepatitis

Herpes
High/Low blood pressure
Kidney disease or problem
Liver disease
Material allergies (latex, wool, metal, chemicals)
Mitral valve prolapse
Nervous problems
Pacemaker/Heart surgery
Psychiatric care
Rapid weight gain or loss
Radiation treatment
Respiratory disease
Rheumatic/Scarlet fever
Shingles

Shortness of breath
Sinus problems
Skin rash
Stroke
Surgical implant
Swelling of feet or ankles
Thyroid problems
Tobacco habit
Tonsillitis
Tuberculosis
Ulcer/colitis
Venereal Disease
Claustrophobia
Pregnant? Due date:
Nursing?

Are you or have you ever taken Diphosphates (i.e. Zometa, Aredia, Fosamax, Actonel or Boniva)?
Yes No

List medications you are currently taking:

Allergic to:

Aspirin	Penicillin	Other:
Codeine	Sulfa	
Latex	Local Anesthetic	

Do you have any disease, condition or problem not listed above?

Insurance Assignment Agreement

I (Dr. Bruchmiller / Gorman) agree to "take assignment" of insurance benefits for your dental treatment, if the fee is in excess of $150.00. We will collect from you what we estimate your part of the fee will be. Then, we file the claim and wait for your insurance company to pay their estimated part. The insurance company may pay more than we estimate in which case you get a refund from us. The insurance company may pay less than we estimate in which case you will owe us the balance of the fee. Your insurance company could deny the whole claim and you could owe the entire bill!

Please keep in mind that the insurance company works for you and your employer and not for us. Sometimes, they will not respond to us and will respond better and faster if you, their customer, call. Also, they set the amount they will pay by what is called the "usual and customary rate" (UCR) which is an average fee for a certain geographic area. Since this is a specialty office and the root canal treatments we do are more complicated and difficult, our fees are often higher than the UCR fee that your insurance bases its benefits on. If you have and questions, please ask one of our staff for more information.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate and healthful endodontic treatment. If there is a change in my medical status, I will inform the endodontist. I authorize the insurance indicated on this form to pay the endodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the endodontist to release all information necessary to secure the payment of benefits.

Signature ____Date: _______________________________