

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 _____ 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 No. _____

Secondary Carrier Address: _____ Phone No. _____

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

Circle if you have ever had any of the following:

AIDS/HIV Positive	Cortisone treatments	Herpes	Shortness of breath
Anaphylaxis	Cough, persistent or bloody	High/Low blood pressure	Sinus problems
Anemia	Diabetes	Kidney disease or problem	Skin rash
Arthritis rheumatism	Epilepsy	Liver disease	Stroke
Artificial heart valves	Fainting	Material allergies (latex, wool, metal, chemicals)	Surgical implant
Artificial joints	Food allergies	Mitral valve prolapse	Swelling of feet or ankles
Asthma	Glaucoma	Nervous problems	Thyroid problems
Atopic (allergy prone)	Headaches	Pacemaker/Heart surgery	Tobacco habit
Back problems	Heart murmur	Psychiatric care	Tonsillitis
Blood disease	Heart problems	Rapid weight gain or loss	Tuberculosis
Bruise easily	_____	Radiation treatment	Ulcer/colitis
Cancer	_____	Respiratory disease	Venereal Disease
Chemical dependency	Hemophilia	Rheumatic/Scarlet fever	Claustrophobia
Chemotherapy	Abnormal bleeding	Shingles	Women: Pregnant? Due date:
Circulatory problems	Hepatitis		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: (circle) Aspirin Codeine Latex Penicillin Sulfa Local Anesthetic Other _____

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 _____