



Patient  Ms.  Mrs.  Mr.  Dr. \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

How would you like to be addressed? \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

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

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

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

Who Referred You to this Office? \_\_\_\_\_

Family Dentist \_\_\_\_\_ Patient's SS # \_\_\_\_\_

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**PRIMARY DENTAL INSURANCE**

Subscriber Name \_\_\_\_\_

Subscriber's SS# or ID# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Group # \_\_\_\_\_

Name & Address of Primary Insurance Co. \_\_\_\_\_

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**SECONDARY DENTAL INSURANCE**

Subscriber Name \_\_\_\_\_

Subscriber's SS# or ID# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Group # \_\_\_\_\_

Name & Address of Secondary Insurance Co. \_\_\_\_\_

**AUTHORIZATION FOR INFORMATION AND INSURANCE RELEASE**

I authorize release of information to my family dentist and to my insurance company(s) in order to process my insurance claim. I understand that I am responsible for all costs of my dental treatment. I understand that this endodontic specialty practice is not a participating provider with any specific insurance plans and that I am responsible for knowing the terms of my own insurance coverage. If fees are not paid in full by me at the time of service, I hereby authorize payment of dental benefits from insurance, otherwise payable to me, directly to James R. Murrin, DDS, MS, Inc.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signed (Employee or Spouse, Parent if minor) Date

**Have you had, or do you presently have any of the following conditions?**

	Yes	No		Yes	No
Heart Attack - Date _____	<input type="radio"/>	<input type="radio"/>	Jaw Joint (TMJ) Problems .....	<input type="radio"/>	<input type="radio"/>
Heart Surgery - Date _____	<input type="radio"/>	<input type="radio"/>	Ulcers .....	<input type="radio"/>	<input type="radio"/>
Heart Disease.....	<input type="radio"/>	<input type="radio"/>	Colitis or Irritable Bowel Syndrome.....	<input type="radio"/>	<input type="radio"/>
Aortic Stenosis .....	<input type="radio"/>	<input type="radio"/>	Surgery or x-ray treatment for a tumor, growth, or other condition of the head, mouth, or lips .....	<input type="radio"/>	<input type="radio"/>
Bacterial Endocarditis.....	<input type="radio"/>	<input type="radio"/>	AIDS or HIV Positive .....	<input type="radio"/>	<input type="radio"/>
Artificial Vascular Graft.....	<input type="radio"/>	<input type="radio"/>	Hepatitis, Jaundice, or Liver Disease.....	<input type="radio"/>	<input type="radio"/>
Chest Pain/Angina Pectoris .....	<input type="radio"/>	<input type="radio"/>	Blood Transfusion.....	<input type="radio"/>	<input type="radio"/>
High/Low Blood Pressure. ....	<input type="radio"/>	<input type="radio"/>	Drug Addiction/Alcoholism .....	<input type="radio"/>	<input type="radio"/>
Heart Murmur .....	<input type="radio"/>	<input type="radio"/>	Hemophilia or Excessive Bleeding .....	<input type="radio"/>	<input type="radio"/>
Rheumatic Fever/Rheumatic Heart Disease .....	<input type="radio"/>	<input type="radio"/>	Sexually Transmitted Disease .....	<input type="radio"/>	<input type="radio"/>
Congenital Heart Lesions/Mitral Valve Prolapse.....	<input type="radio"/>	<input type="radio"/>	Cold Sores/Herpes.....	<input type="radio"/>	<input type="radio"/>
Artificial Heart Valve .....	<input type="radio"/>	<input type="radio"/>	Glaucoma .....	<input type="radio"/>	<input type="radio"/>
Heart Pacemaker .....	<input type="radio"/>	<input type="radio"/>	Depression/Psychiatric Treatment .....	<input type="radio"/>	<input type="radio"/>
Artificial Joint/Prosthesis.....	<input type="radio"/>	<input type="radio"/>	Allergies/Hay Fever .....	<input type="radio"/>	<input type="radio"/>
Stroke .....	<input type="radio"/>	<input type="radio"/>	Asthma .....	<input type="radio"/>	<input type="radio"/>
Kidney Disease.....	<input type="radio"/>	<input type="radio"/>	Sinus Trouble.....	<input type="radio"/>	<input type="radio"/>
Cancer or Tumors.....	<input type="radio"/>	<input type="radio"/>	Seizures/Epilepsy .....	<input type="radio"/>	<input type="radio"/>
Thyroid Disease.....	<input type="radio"/>	<input type="radio"/>	Arthritis.....	<input type="radio"/>	<input type="radio"/>
Lung Disease/Tuberculosis.....	<input type="radio"/>	<input type="radio"/>	Phen-Fen or Redux Diet .....	<input type="radio"/>	<input type="radio"/>
Diabetes .....	<input type="radio"/>	<input type="radio"/>			

**Have you ever had an allergic or unusual reaction to any of the following?**

	Yes	No		Yes	No
Local Anesthetics ("Novocaine").....	<input type="radio"/>	<input type="radio"/>	Penicillin .....	<input type="radio"/>	<input type="radio"/>
Aspirin or Ibuprofen (Advil) .....	<input type="radio"/>	<input type="radio"/>	Erythromycin or Other Antibiotics .....	<input type="radio"/>	<input type="radio"/>
Acetaminophen (Tylenol).....	<input type="radio"/>	<input type="radio"/>	Tetracycline .....	<input type="radio"/>	<input type="radio"/>
Barbiturates/Tranquilizers (Sleeping Pills) .....	<input type="radio"/>	<input type="radio"/>	Any Other Medication or Drugs.....	<input type="radio"/>	<input type="radio"/>
Codeine or Other Narcotics .....	<input type="radio"/>	<input type="radio"/>	Which Ones? _____		
Latex/Rubber Materials .....	<input type="radio"/>	<input type="radio"/>	_____		
			_____		

**Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel, Fosamax, or Zometa?**

\_\_\_\_\_

**Are you currently a smoker, or a user of tobacco products? Yes  No**

**Women:**

	Yes	No	
Are You Pregnant?.....	<input type="radio"/>	<input type="radio"/>	If Yes, How Many Months? _____
Do You Anticipate Becoming Pregnant? .....	<input type="radio"/>	<input type="radio"/>	
Are You Breast Feeding?.....	<input type="radio"/>	<input type="radio"/>	

**Please list any medications (over the counter, prescription, or herbal/alternative) that you are taking now:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**If you have had any serious complications involving dental treatment, please explain:**

\_\_\_\_\_

**Informed Consent:** I understand that root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Occasionally, a patient may experience post-operative discomfort or swelling which may require medication for several days. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require re-treatment, surgery, or even extraction.

\_\_\_\_\_  
**Patient (or Guardian) Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Updates**