RIVER VALLEY ENDODONTICS PA

Gentle, personalized, lasting solutions… one patient at a time.

Mary Ann Bunczak-Reeh DDS
Ernest S. Reeh DDS, MS, PhD
Diplomate of the American Board of Endodontics

Personal Information: Name _____Phone ( )_____
Work Phone ( ) _____Cell Phone ( ) _____
Address_____City _____ State ____ Zip _____
Social Security Number _____ Date of Birth _____
Account Responsibility: Name_____ Phone ( )_____
Social Security Number _____ Date of Birth _____
Employer _____Occupation _____Phone ( )_____
Emergency Contact: Name _____**Relation:**_____Phone ( ) _____
Address_____City _____ State ____ Zip _____
Nearest Relative: (not living with you) Name_____ Phone ( )_____
Address_____City _____ State ____ Zip _____
Referring Dentist: Name _____DDS Phone ( )_____

Health History: The following information will remain confidential
Name of Medical Doctor _____MD Phone ( )_____
Address _____City _____ State ____ Zip _____

1. Are you currently being treated by a physician? If yes, for what condition: _____

2. Do you require antibiotic premedication for:
- Artificial Joint
- Artificial Heart Valve
- Congenital Heart Disease
- Heart Murmer
- Mitral Valve Prolapse
- Rheumatic Fever
- OTHER:

_____

3. Do you have any allergies or bad reactions to:
- Penicillin
- Other Antibiotics:

_____
- Antiinflammatories
- Latex
- Epinephrine
- OTHER:

_____

4. Are you taking any of the following medications:
- Antibioitic(s)
- Birth control
- Blood pressure
- Coumadin/Warfarin/Aspirin
- Depression
- Insulin
- Pain
- **PLEASE LIST ALL MEDICATIONS:** (including diet drugs and herbal remedies)

_____
_____
_____
_____
_____
_____

5. Do you have, or have you had, any of the following conditions:
- Asthma
- Blood disorder
- Cancer
- Chemical dependency
- Diabetes
- Epilepsy
- Gastrointestinal disorder.
- Heart problems
- High Blood Pressure
- HIV / AIDS / TB
- Liver disorder/Hepatits
- Kidney disorder
- Pacemaker
- Stomach Ulcer
- Stroke
- TMJ Disorder
- OTHER: _____

WOMEN: Are you presently:
- Pregnant
- Breast Feeding

6. Is there anything else you feel we should know about your health that was not covered? If yes, please list:

_____

American Association of Endodontists
Specialist Member

PAYMENT OPTIONS

We are committed to providing you with the best possible care and we are willing to discuss professional fees with you at any time. Your understanding of our payment options is important to our professional relationship. Please ask if you have any questions about our fees or your responsibility.

- All patients are required to complete and sign this form before seeing the doctor.
- With or without insurance, you are responsible for the timely payment of your account.
- Payment is due at the time of your service, unless other financial arrangements are made in advance.
- We accept Cash, Check, Visa, MasterCard and Discover.
- After 30 days interest accrues at the rate of 1.5% per month (18% APR) on the outstanding balance. (Whether your insurance company has paid or not.)
- A credit report may be used to determine financial arrangements.
- If collection action becomes necessary, the responsible party will be held liable for interest, collection costs of 25 percent, and legal costs up to 50 percent.
- What method of payment will be used on your account.

• Cash • Check • Visa • MasterCard • Discover • Care Credit Financing

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IDENTIFICATION: Drivers Lic#_____ State_____

DENTAL BENEFITS: Is a contract between you and your insurance company. We file insurance claims as a courtesy to you and will work with you to attain the benefits to which you are entitled. We will not become involved in disputes between you and your insurance company other than to supply factual information about treatment provided.

First Insurance Company: Name_____ Phone (___)_____
Address_____ City_____ State___ Zip_____
Policy Holder_____ Social Security #_____-____-_____
Date of Birth_____/_____/_____ Group or ID #_____

Second Insurance Company: Name_____ Phone (___)_____
Address_____ City_____ State___ Zip_____
Policy Holder_____ Social Security #_____-____-_____
Date of Birth_____/_____/_____ Group or ID #_____

I have read through the payment options and I understand my obligations and responsibilities.

Signature_____ Date_____
(responsible party must sign if patient is a minor)

I acknowledge I have had the opportunity to read and have a copy of the Privacy Practices of the clinic.

Signature_____ Date_____

We attempted to obtain written acknowledgement of our Privacy Practices but acknowledgement could not be obtained because: