West Houston Endodontics

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Mei I Tang, D.D.S

PATIENT INFORMATION

Date:_____
Prefix: Mr. Mrs. Ms. Dr.
Patient Name:_____
(last) (first) (middle) (nickname)

Address:_____
(street) (apt#) (city) (state) (zip code)

Phone:_____ _____ _____
(home) (work) (cell)
Email address:_____

Patient SS#:_____ Patient Driver's Lic#:_____
Patient Birth Date:_____/_____/_____ Patient Gender: Male_____ Female_____
Patient Employer_____ Occupation_____

Spouse/ Other Name:_____
Employer:_____
(If under 18) Parent Name:_____ Phone:_____

***Referring Dentist _____

DENTAL INSURANCE INFORMATION

Insured Name_____ Ins SS#:_____
(last) (first) (middle) Birth date_____/_____/_____

Employer:_____
Insurance Co.:_____ Group #:_____
Ins Co Address:_____
(street) (city) (state) (zip)
Secondary Insurance:_____

FINANCIAL POLICY AND INSURANCE ASSIGNMENT

I, the undersigned certify that I (or my dependent) have insurance coverage with the above stated company and assign directly to Dr. Plum all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event that the insurance company does not make a payment towards my account within 90 days, I will remit a payment for the full balance as expected. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____/_____/_____
Responsible Party Signature Relationship Date

If dental insurance applies: Although this dental office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any differences of payment is entirely the responsibility of the patient.

INITIALS_____ DATE_____

MEDICAL HISTORY

Please Indicate a YES/NO for each condition:

Previous Heart Attack/Stroke	YES/NO	Kidney Disease/Dialysis	YES/NO
Previous Heart Surgery	YES/NO	Epilepsy/Seizures	YES/NO
Mitral Valve Prolapse	YES/NO	Cancer	YES/NO
Heart Murmur/Rheumatic Fever	YES/NO	Radiation	YES/NO
Artificial Heart Valves	YES/NO	Chemotherapy	YES/NO
Pacemaker	YES/NO	Glaucoma	YES/NO
Artificial Joints	YES/NO	Hemophilia	YES/NO
Angina	YES/NO	Hepatitis A/B/C/D	YES/NO
High Blood Pressure	YES/NO	Drug Addiction	YES/NO
Thyroid Disease	YES/NO	AIDS/HIV	YES/NO
Tuberculosis	YES/NO	Pregnant (Females Only)	YES/NO
Asthma	YES/NO	Birth Control Pills	YES/NO
Ulcers	YES/NO	Have you ever used steroids?	YES/NO
Latex Allergy	YES/NO	Have you ever taken Phen-fen?	YES/NO
Sinus Trouble	YES/NO	Do you take anticoagulants?	YES/NO
Diabetes	YES/NO	Do you take a bisphosphonate?	YES/NO

Any Other Medical Conditions Not Listed: YES/NO
If Yes, please list: _____

Please list all medications you are currently taking: _____
_____
_____

Please list any drug allergies you have: _____
Physician's Name: _____
Physician's Phone #: _____

*** **Signature**: _____ Date: _____

In case of Emergency, please contact _____
Address: _____ Home #: _____
Work #: _____ Cell #: _____ Relationship: _____

For Office Use Only

Notes: _____ Doctor: _____
Blood Pressure: _____ Date: _____
Pulse: _____ Updated on: _____

Doctor's Comments:

_____
_____
_____
_____
_____
_____