



Advanced Endodontics of Houston

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PERSONAL MEDICAL HISTORY

Do you have/have been informed that you had any of the following (Please Circle yes or no):

Heart Condition	yes no	Diabetes	yes no	Visual Problems	yes no
Heart Attack	yes no	Kidney Problems	yes no	Hepatitis A/B/C/D	yes no
Heart Murmur	yes no	Herpes	yes no	Cancer	yes no
High Blood Pressure	yes no	Thyroid	yes no	Chemotherapy	yes no
Respiratory/Asthma	yes no	Ulcers/Digestive	yes no	Tuberculosis	yes no
Rheumatic Fever	yes no	Mitrovalveprolapse	yes no	AIDS/HIV	yes no
Bleeding Hemophilia	yes no	Seizures	yes no		

Any other medical conditions not listed? Yes No Height _____ Weight _____

If yes, please list: _____

Please list all medications you are currently taking: _____

Please list all drug allergies you have: _____

(Women) Are you currently pregnant? Yes No Taking Birth Control Pills? Yes No

RESPONSIBLE PARTY

Who is responsible for this patient?

Name _____ Relationship _____

Social Security # _____ Sex _____ Date of Birth _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Work (_____) _____ Cell (_____) _____

DENTAL INSURANCE INFORMATION

Dental Coverage Yes No

Insured's Name _____ Relationship _____

Insured's Social Security # _____ Date of Birth _____

Insured's Employer _____ Phone Number (_____) _____

Insurance Policy ID # _____ Insurance Group # _____

Insurance Co. Name _____ Phone Number (_____) _____

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. Zamany 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 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.

SIGNATURE _____ **DATE** _____

Although this office files insurance claims as a service to our patients, 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 difference of payment is entirely the responsibility of the patient.