Tangredi Endodontics, P.C.
1100 Franklin Avenue- Suite 301/302 Garden City, NY 11530 | PH: (516)746 -3636 | Fax: (516)746-0270
6306 Jericho Turnpike, Commack, NY 11725 | PH: (631)462-6888

Welcome to Our Practice!

Patient Name: _____ _____ _____ _____
Last First MI Preferred

Gender: __ Male __ Female Family Status: __ Married __ Single __Child __ Other

Birth Date: _____
If under 18 years old, please provide guardian information below:
Guardian name: _____Date of Birth: _____

Title: _____
Mr/Mrs/Ms
SS#: _____
Prev. Visit: _____

Email Address: _____ Best Time To Call: _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext. Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip

Dental Information

General Dentist Name: _____

General Dentist Address: _____

General Dentist Phone Number: _____

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Tangredi Endodontics, P.C.
1100 Franklin Avenue- Suite 301/302 Garden City, NY 11530 | PH: (516)746 -3636 | Fax: (516)746-0270
6306 Jericho Turnpike, Commack, NY 11725 | PH: (631)462-6888

Medical History

Indicate which of the following currently apply. By Checking the box it will indicate a "Yes" response, leaving it blank will indicate a "No" response.

☐ Pre-Med Amox	☐ Pre-Med Clind	☐ Pre-Med Other	☐ A-FIB
☐ Allergy-Aspirin	☐ Allergy-Codeine	☐ Allergy-Erythro	☐ Allergy-Hay Fever
☐ Allergy-Latex	☐ Allergy-Lidocaine	☐ Allergy-Other	☐ Allergy-Penicillin
☐ Allergy-Sulfa	☐ Allergy-Clind	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Blood Disease	☐ Cancer
☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting
☐ Glaucoma	☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur
☐ Hepatitis	☐ High Blood Pressure	☐ HIV	☐ MCTD
☐ Mental Disorders		☐ Nervous Disorders	☐ Other
☐ Pacemaker	☐ M.S.	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatism	☐ Pregnant		☐ Tuberculosis
☐ Venereal Disease	☐ Sinus Problems	☐ Stroke	☐ Diabetes

If any condition or alerts selected above needs further clarification, please explain below:

_____

_____

Are there any other medical conditions, not listed above, that we need to be aware of?

_____

_____

Describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment:

_____

_____

List all medications taken within the last year:

_____

_____

I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Signature_____ **Date:** _____

Tangredi Endodontics, P.C.
1100 Franklin Avenue- Suite 301/302 Garden City, NY 11530 | PH: (516)746 -3636 | Fax: (516)746-0270
6306 Jericho Turnpike, Commack, NY 11725 | PH: (631)462-6888

Insurance Information

Primary Dental Insurance:
Do you have any dental insurance? _____ Yes _____ No
Are you the policy Holder? _____ Yes _____ No
Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____

ID#: _____ Group #: _____

Insured's Address: _____ _____
Address 1 (if different than home address) Address 2

_____ _____ _____
City State Zip

Patient's relationship to insured: _____ Self _____ Spouse _____ Child _____ Other

Insured's Employer Name: _____

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip

Secondary Dental Insurance:
Do you have any dental insurance? _____ Yes _____ No
Are you the policy Holder? _____ Yes _____ No
Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____

ID#: _____ Group #: _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip

Patient's relationship to insured: _____ Self _____ Spouse _____ Child _____ Other

Insured's Employer Name:_____

Insurance Plan Name: _____

Insurance Address: _____ _____
Address City, State, Zip

Tangredi Endodontics, P.C.
1100 Franklin Avenue- Suite 301/302 Garden City, NY 11530 | PH: (516)746 -3636 | Fax: (516)746-0270
6306 Jericho Turnpike, Commack, NY 11725 | PH: (631)462-6888

-Insurance Financial Agreement-

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment listed below. I understand my dental condition and will discuss several treatment options with the undersigned provider.

I understand that the FINAL Insurance Payment is based on many factors, which could result in a payment that is different from the amounts estimated. It has been explained to me that if my yearly insurance maximum has been reached, my insurance payment could be lower than the estimated payment or result in no payment at all.

I further understand that the **insurance estimate** does not take into account any deductions or any outstanding claims not yet processed. The estimated Patient Payment MUST be paid prior to completion of treatment.

I assume full financial responsibility for my account balance, including any amounts not payable by my dental insurance. I agree that I must pay any outstanding balance at the completion of my treatment. Accepted payment methods include: Cash, Check, Visa, MasterCard, Discover, American Express, and
CareCredit.

I have read, agree to and understand the statements listed above.

Signature: _____
Date: _____

-Financial Agreement-

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment listed below. I understand my dental condition and will discuss several treatment options with the undersigned provider.

I understand that all dental services are charged directly to the patient and that I am responsible for payment of all dental services rendered at the time of the treatment.

The office will help prepare the insurance forms or assist in making collections from insurance companies,

I assume full financial responsibility for my account balance. I agree that I must pay any outstanding balance at the completion of my treatment. Accepted payment methods include: Cash, Check, Visa, MasterCard, Discover, American Express, and CareCredit.

I have read, agreed to and understand the statements listed above.

Signature: _____
Date: _____

-Financial Policy-

In the event that endodontic treatment is started and not completed, I, the undersigned patient agrees to pay half of the treatment fee. Refunds will be left to the discretion of the Treatment Coordinator.

I have read, agreed to and understand the statement listed above.
Signature: _____
Date: _____

Tangredi Endodontics, P.C.
1100 Franklin Avenue- Suite 301/302 Garden City, NY 11530 | PH: (516)746 -3636 | Fax: (516)746-0270
6306 Jericho Turnpike, Commack, NY 11725 | PH: (631)462-6888

HIPPA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I understand the above information and agree with its contents.

Signature_____

Date _____

Tangredi Endodontics, P.C.
1100 Franklin Avenue- Suite 301/302 Garden City, NY 11530 | PH: (516)746 -3636 | Fax: (516)746-0270
6306 Jericho Turnpike, Commack, NY 11725 | PH: (631)462-6888

We offer a variety of payment options.

Please check below your choice of payment for the services provided.

____ Payment by cash

____ Payment by check

____ Payment by credit or debit card

____ Payment by CareCredit

By signing below, you acknowledge your responsibility for the services provided and agree to pay for your treatment by the payment method checked above.

Print Name: _____

Signature: _____

Date: _____

Tangredi Endodontics, P.C.
1100 Franklin Avenue- Suite 301/302 Garden City, NY 11530 | PH: (516)746 -3636 | Fax: (516)746-0270
6306 Jericho Turnpike, Commack, NY 11725 | PH: (631)462-6888

Electronic Communication Consent

I, _____, give Tangredi Endodontics PC, permission to send me electronic communications via email and/or text regarding appointments, billing and insurance.

Text messaging: Yes □ No □ Initials _____

Emails: Yes □ No □ Initials _____

I acknowledge that I am responsible for providing the dental practice with any updates to my email address or cell phone number. I am able to receive information electronically and via text and store it securely away from any public computer or cell phone. I can withdraw my consent to electronic communications at any time by calling (516)746-ENDO(3636).

_____ _____

Patient Signature Date

Credit Card Information

Tangredi Endodontics PC, is equipped with the latest payment technology and a paperless office. This enables us to make payments efficiently and without unnecessary paper.

Please store your credit information on file with us so we can conveniently charge account balances without burdening you.

Name on card: _____

Credit Card Number: _____

Expiration Date: _____

CVV: _____

By signing below, I am giving Tangredi Endodontics PC, permission to charge my credit card when I have a remaining responsibility. I acknowledge that I am responsible for providing the dental practice with any updates to my credit card. I can withdraw my consent to having Tangredi Endodontics PC charging my credit card at any time by calling (516)746-ENDO(3636).

_____ _____

Patient Signature Date