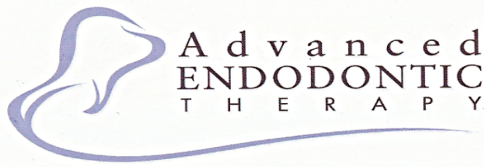

Jacob L. Fimple, DDS, MMSc
18015 Oak St., Suite A
Omaha, NE 68130
402.763.4929 (phone)
402.502.5990 (fax)

Patient: ____ Birthdate: ______________
(First name) (Initial) (Last name)
Home Address: ____Apt #__________________
City: ____________________State:_______________Zip:_______________ Social Security#: __________________
Home Phone: __________________ Cell Phone: ___________________ Email: ____________________________

Emergency Contact: _______________________________________ Phone: ____________________________
Referring Dentist: ____ Phone: ____________________________
Physician's Name: ____ Phone: ____________________________

Patient Employed By: ____
Business Address: ____
Occupation: ____ Business Phone: ____________________________

Primary subscriber information: ___________________________ Subscriber's Employer: _______________________
Subscriber Social Security #:______________________________ Subscriber's Birthdate: ________________________

Is the patient covered by additional insurance? ☐ Yes ☐ No If yes, Please complete:
Subscriber Name: __________________________ Subscriber's Employer: __________________________________
Subscriber Social Security #:______________________________ Subscriber's Birthdate: ________________________

Which of the following methods of payment will you be using? (Fees must be paid in full at time of service.)
Method of Payment: ☐ Cash ☐ HSA ☐ Visa ☐ Mastercard ☐ Discover ☐ Care Credit Financed

		YES	NO
1.	Have there been any changes in your general health within the past year? Please Specify____	☐	☐
2.	Have you been treated by a physician during the last five years?	☐	☐
3.	Have you ever been treated for a drug or alcohol addiction?	☐	☐
4.	Are you taking any medications now? (Aspirin, Birth Control Pills, etc.) Please Specify ____	☐	☐
5.	**Are you sensitive or allergic to *novocaine*, *codeine*, or *any other medications or latex products*?** ______________________________	☐	☐
6.	Have you ever had an unfavorable reaction to local anesthetic?	☐	☐
7.	Have you ever had excessive bleeding requiring special treatment?	☐	☐
8.	Have you ever had any of the following illnesses? **If so, please circle**. TMJ, sinus trouble, stroke, heart trouble, high blood pressure, rheumatic fever, asthma, tuberculosis, hepatitis, jaundice, kidney disease, diabetes, epilepsy, nervous disorder, anemia, scarlet fever, fainting, dizzy spells, thyroid problems, venereal disease, AIDS or HIV (+) Other: ___________________________________	☐	☐
9.	Have you ever had any other serious illness? Please Specify ____	☐	☐
10.	Have you ever been told that you have a heart murmur and/or mitral valve prolapse?	☐	☐
11.	Do you have any artificial valve, joints, or prosthesis?	☐	☐
12.	Female patients: Are you nursing or pregnant? If so, which month?_______	☐	☐

*All of the above information is true to the best of my knowledge. Initials: _________ Date: _______________

PERMISSION FOR ROOT CANAL PROCEDURE

I understand that root canal treatment is an attempt to retain a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had a root canal therapy may require retreatment, surgery or even extraction. I also understand that the permanent (outside) restoration (filling, inlay, crown, and ect.) will be completed by my regular dentist.

Date: __________ Patient's/Parents'signature______________________________________Reviewed:___________

If dental insurance applies: Although this 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 or payment, any difference is entirely the responsibility of the patient. I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me. Initials: _________ Date:______________

Please be sure that cell phones/paging devices are turned off. Thank you!