



CAMEO ENDODONTICS

Richard A. Munaretto, DDS, MS
Raymond F. Munaretto, DDS
Rick A. Munaretto, DDS
Diplomate, American Board of Endodontics

Keith Sommers, DDS
Regina Rocha, DDS, MS
Richard A. Kohn, DDS, MS

Welcome to Cameo Endodontics, Ltd.

Health Form 1

Please complete all pages – Thank you.

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security Number: _____

Please check one: Single Married Widowed Divorced Separated

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: (_____) _____ Work Telephone: (_____) _____

Cell Phone: (_____) _____ Best place to reach you: _____

Occupation: _____ Employed by: _____

Business Address: _____

Referring/General Dentist: _____

Primary Dental Insurance Information:

Insurance Company Name: _____

Insurance Address: _____

Telephone: (_____) _____ Group Number: _____

Name of Insured: _____ Social Security: _____

Insured DOB: _____ Employer : _____

Secondary Dental Insurance Information:

Insurance Company Name: _____

Insurance Address: _____

Telephone: (_____) _____ Group Number: _____

Name of Insured: _____ Social Security: _____

Insured DOB: _____ Employer : _____

If a Minor (under age 21)

Parents Name: _____ Social Security: _____

Home Telephone: (_____) _____ Work Telephone: (_____) _____

Elmwood Park Office
Cameo Endodontics, Ltd.
7234 West North Avenue, Suite 202
Elmwood Park, IL 60707
T: (708) 456-7787
F: (708) 456-2574

Berwyn Office
Cameo Endodontics, Ltd.
3116 Oak Park Avenue
Berwyn, IL 60402
T: (708) 484-9011
F: (708) 484-9061

LaGrange Office
Cameo Endodontics, Ltd.
475 West 55th Street, Suite 208
LaGrange, IL 60525
T: (708) 579-0488
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Health Form 2

Please complete all pages – Thank you.

Medical Information:

Have you ever had *(Please Circle Yes or No)*

Heart Trouble	Yes	No	Rheumatic Fever	Yes	No
Convulsions	Yes	No	Asthma	Yes	No
High Blood Pressure	Yes	No	Thyroid Problems	Yes	No
Nervous Disorders	Yes	No	Anemia	Yes	No
Bleeding Problems	Yes	No	Hepatitis	Yes	No
Diabetes	Yes	No	HIV+	Yes	No

Are you currently taking or have taken bisphosphonate medications, such as Actonel, Fosamax or Zometa, within the past twelve years? Yes No

Have you had a hip, joint, or valve replacement? Yes No
If so, when? _____

Does your physician tell you to premedicate with an antibiotic before dental appointments for any medical condition? Yes No

Have you ever taken any medicines for your heart or high blood pressure? Yes No

Are you now taking any kind of medicine, drug, alcohol or pills for any purpose? Yes No
If so, what? _____

Are you allergic to any food, medicine, or drug? Yes No
If so, what? _____

Are you allergic to local anesthetic? Yes No

Are you allergic to latex? Yes No

Have you been under the care of a physician during the last year? Yes No
Name of Physician _____

Is there any condition concerning your health the doctor should be told? Yes No
If so, what? _____

Have you ever had Root Canal Therapy before? Yes No

Women Are you pregnant or breast feeding? Yes No

I certify that these statements concerning my health are correct to the best of my knowledge.

Date: _____ Signed: _____

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Health Form 3

Please complete all pages – Thank you.

Fee Schedule:

Our Usual Fees:	Anterior (front teeth)	\$950.00 and up
	Bicuspids (middle teeth)	\$1,050.00 and up
	Molars (back teeth)	\$1,150.00 and up
	Consultation	\$95.00
	Retreatments	Additional Fee

The above fees do not include the final restoration by your general dentist. You will leave our office with a temporary filling after the root canal therapy. You are responsible to followup with your dentist after treatment is completed in our office. **There is a \$45.00 charge for all missed appointments.**

Our Financial Policy:

With Insurance

We will gladly bill your dental insurance company for any charges incurred in our office. We do require those with insurance to provide us with sufficient information to bill your insurance company. **Any benefit information we obtain from your insurance company is an estimate and only done as a courtesy.** You are ultimately responsible for any balance on your account. We require you to pay your estimated portion the day services are rendered. We will send you a statement or refund once the insurance has paid if there is any difference.

SelfPay

We ask that the services provided are paid in full by the time they are completed. If two visits are required 50% is due today and the remainder at the following visit.

All patients please read and sign the following:

I have read and understand the above policies. I authorize the release of any information to my insurance company pertaining to any services rendered. I also authorize payment to be made directly to the dentist. I am aware that any unpaid balance after work is completed is subject to an 18% finance charge. Any collections fees for delinquent accounts is the responsibility of the patient, fees equal 1/3 of balance.

Signature: _____ Date: _____

Payment Option

We offer the option to leave your credit card number on file. We will then bill your insurance and apply any balance to your card after they have paid. If interested please fill out the following.

Visa Mastercard Discover American Express

Card Number: Exp: / Signature code: _____

I authorize Cameo Endodontics to charge my credit card for the balance on my account.

Signature: _____ Date: _____

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