

**Geraldine Ross Bills DDS, P.A.**  
**875 Walnut St., Ste 200 (York Properties Building)**  
**Cary, NC 27511**  
**Office: 467-8227 / Web page: [www.rootcanalsincary.com](http://www.rootcanalsincary.com)**

Name of patient: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate: \_\_\_\_\_ Email address: \_\_\_\_\_

Best # to reach you: \_\_\_\_\_ Alternate: \_\_\_\_\_ Text capable? Y N

Employer: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Name of general dentist: \_\_\_\_\_

Circle medication you may be allergic or sensitive to:

Penicillin    Erythromycin    Epinephrine    Codeine    Sulfa    Anti-inflammatory drugs

Other: \_\_\_\_\_

Medications currently taking: \_\_\_\_\_

Circle Health Conditions that apply:

Heart murmur	Kidney Disease	Tuberculosis	HIV/AIDS
Heart Valve dysfunction	Hypertension	Epilepsy	Stroke
Diabetes	Asthma	Hyper/Hypoglycemia	Dental Phobia

Are you required to take antibiotics prior to dental work for either a heart problem or a joint replacement? Yes\_\_\_\_ No\_\_\_\_ If yes, name of medication: \_\_\_\_\_

Do you have any serious medical condition we should be aware of? Yes\_\_\_\_ No\_\_\_\_

If yes, please explain: \_\_\_\_\_

Female Patients: Pregnant? Yes\_\_\_\_ No\_\_\_\_ Breast feeding? Yes\_\_\_\_ No\_\_\_\_

Person to contact in the event of an emergency while you are in our office:

Name: \_\_\_\_\_ Tele. #: \_\_\_\_\_

**(Turn over for additional information)**

Our Procedures and Fees:

Consultations: 125 -150 (depending on # of teeth evaluated)

Root Canal Therapy:

**Anterior** (front teeth) 995 **Bicuspid** (side) 1100-1150 **Molar** (back) 1250

RC Retreatments: \$ 100-200 in addition to the cost of root canal therapy,  
depending on difficulty removing prior filling or post

Permanent Composite Restoration: \$ 175

Apicoectomy \$1250-1400

Methods of Payment:

**Payment is expected on the date of service.** We accept cash, check, or a major credit card (Visa, Master Card, Discover, American Express.) For patients interested in financing their dental visit, we offer a 6 month interest free plan through Care Credit. Applications can be made online through CareCredit.com. (**must be approved prior to dental visit.**)

Type of payment:

Cash\_\_\_\_ Check\_\_\_\_ Credit Card\_\_\_\_ Care Credit\_\_\_\_

Patients with Insurance:

While our office would be happy to file your insurance for you, we are not affiliated with any insurance plans. Therefore, you must check with your insurance company prior to coming in for treatment to determine if your plan covers your dental procedure. If you have provided the following information, your claim will be filed on the date of your visit. For patients unable to provide the necessary insurance information, you will be given a claim form to file your insurance. Insurance companies are asked to pay you directly. If the check is sent to our office in error, Dr. Bills will issue you a check from her on-line banking account within 24 hours after receiving the reimbursement.

**Insurance Co:** \_\_\_\_\_

**Address of Insurance Carrier:** \_\_\_\_\_

**Name of Employer:** \_\_\_\_\_

**Are you the Employee?** Yes\_\_\_\_ No\_\_\_\_ **Spouse?** Yes\_\_\_\_ No\_\_\_\_ **Child?** Yes\_\_\_\_ No\_\_\_\_

**Name of Employee:** \_\_\_\_\_

**Employee's SS #:** \_\_\_\_\_ **Ins. I.D. #:** \_\_\_\_\_

**Employer Group or Plan #:** \_\_\_\_\_ **Employee Date of Birth** \_\_\_\_\_

**I have read and understand both sides of this form**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_