PATIENT REGISTRATION

Date: _____ Date of Birth: _____

Patient Name _____ SS #: _____

☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address Street: _____

City: _____ State: _____ Zip: _____

Phone Numbers Home: ( ) _____ Business: ( ) _____

Mobile: ( ) _____ Email: _____

Employer _____

If patient is a minor, who is legally responsible? _____

SS# _____ DOB _____

In case of emergency, who should we contact? _____

Phone: ( ) _____ Relationship: _____

Referred by: _____

Method of Payment: ☐ Cash ☐ Check ☐ Visa or Mastercard

INSURANCE INFORMATION

Is treatment covered by insurance? ☐ Yes ☐ No

Name of Insurance Company _____ Phone:( ) _____

Insurance Address: _____

Subscriber's Name: _____ SS#: _____

Date of Birth: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Group or Policy Number: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Name of Secondary Insurance Company _____ Phone: ( ) _____

Insurance Address: _____

Subscriber's Name: _____ SS#: _____

Date of Birth:: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Group or Policy Number: _____

I hereby authorize payment of the dental and insurance benefits and authorize the release of dental information to my insurance company in order for claims to be processed. I have received the financial agreement for insurance.

_____

Patient or Guardian Signature

HEALTH HISTORY

PATIENT NAME _____ DATE _____

1. Are you experiencing pain from your mouth at this time? _____ If so, where? _____
2. Have you noticed any loose teeth? _____
3. Are your teeth sensitive to hot, cold or sweets? _____ Which ones? _____
4. On a scale of 0-10, how important are your teeth to you? _____
5. Do you consider your general health to be Good? _____ Fair? _____ Poor? _____
6. When was your last physical evaluation? _____ Findings? _____
7. Has your health changed within the last year? _____ Explain: _____
8. Are you being treated by your physician at this time? _____ If so, why? _____
   Name of physician: _____ Phone: ( ) _____
9. Have you taken bisphosphonates? _____
10. Are you taking any medications, drugs, pills regularly? _____ if so, please list below: _____

    _____ _____ _____ _____ _____

    _____ _____ _____ _____ _____

11. Have you ever had, or do you now have, any of the following?

☐ AIDS/HIV	☐ Blood Disease	☐ Glaucoma	☐ Liver Problems	☐ Rheumatism
☐ Anemia	☐ Bowel Disease	☐ Heart Attack	☐ Low Blood Pressure	☐ Sinus Problems
☐ Angina	☐ Chemotherapy	☐ Heart Disease	☐ Lung Problems	☐ Skin Disease
☐ Arthritis	☐ Clotting Problems	☐ Heart Murmur	☐ Malignancy/Cancer	☐ Stomach Problems
☐ Artificial Heart Valve	☐ Cold Sores	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Hip, Knee	☐ Congestive Heart Failure	☐ Herpes I or II	☐ Pacemaker	☐ Thyroid Disease
☐ Asthma	☐ Diabetes	☐ High Blood Pressure	☐ Psychiatric Treatment	☐ Tuberculosis
☐ Bladder Problems	☐ Emphysema	☐ Jaundice	☐ Radiation Therapy	☐ Ulcer(s)
☐ Bleeding Problems	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever	☐ Venereal Disease

    Women: Are you pregnant? _____ Which month? _____
    Oral contraceptives? _____ Are you taking hormones? _____
12. Have you taken Cortisone/Steroids within the last 2 months? _____
13. Have you taken anti-coagulants (bloodthinner)? _____ When and for how long? _____
14. Note, the drug(s) you have had an allergic reaction or reacted adversely to:

☐ Advil	☐ Aspirin	☐ Darvon	☐ Local Anesthetics	☐ Tetracycline
☐ Antibiotics	☐ Barbiturates	☐ Demerol	☐ Novocaine	☐ Tylenol
☐ Antihistamines	☐ Codeine	☐ Halcion	☐ Penicillin	☐ Valium

    Other _____
15. Have you had major surgery within the last 2 years? _____ Explain? _____

    _____
16. Please describe any current medical treatment, impending operations, or other medical or dental information that may possibly affect your endodontic care: _____

To the best of my knowledge all of the preceding answers are true and correct. If I have any changes in my health, or if my medications change, I will inform my dentist at the next appointment without fail. I further agree to pay all finance charges, collection cost 50%, attorneys fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

_____ _____

Date Signature of Patient or Guardian

Print Form