Patient Registration Form

We would appreciate your completing **both sides** of this form to the best of your ability. If you have any questions please do not hesitate to ask one of our staff to assist you.

Please Print

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Endodontic Specialists P.C.

Patient Biography

Circle appropriate title: Dr. Mr. Mrs. Miss Ms.			☐ Male ☐ Female
Name: Last First Middle Initial		Preferred Name:	
Address:			
City:		State:	ZIP Code:
Date of Birth:	Age	Social Security Number:	
Name of Parent or Guardian if Applicable:			
Home Phone:	Work Phone:	Cell:	
Email Address:			
Occupation:	Employer:	Employer's Address:	
Marital Status: ☐ Single ☐ Married ☐ Widow(er) ☐ Divorced			
Spouse's Name:		Spouse's Employer:	
Spouse's Cell:		Spouse's Work Phone:	
Spouse (or Guardian) address if different from above:			

Dental Insurance Information

Primary Insurance Co.:		Secondary Insurance Co.:	
Insured's Name and Relationship to Patient:		Insured's Name and Relationship to Patient:	
Insured's Soc. Sec. # or ID #:	Date of Birth:	Insured's Soc. Sec. # or ID #:	Date of Birth:
Insured's Employer:		Insured's Employer:	
Group #:		Group #:	

Health Providers

Dentist (General):	Phone:
Dentist (Specialist):	Phone:
Physician:	Phone:
Pharmacy and Pharmacy Address:	Phone:

Medical History

Please X below

Yes	No	Condition
☐	☐	High Blood Pressure
☐	☐	Bleeding Tendency
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Lung Disease
☐	☐	Thyroid
☐	☐	Anxiety
☐	☐	Psychiatric Disorder
☐	☐	Seizure Problems/Epilepsy
☐	☐	Ulcers
☐	☐	Heart Attack Date: _____
☐	☐	Cardiac Surgery Date: _____ Procedure: _____
☐	☐	Rheumatic Fever
☐	☐	Mitral Valve Prolapse
☐	☐	Heart Murmur
☐	☐	Pacemaker
☐	☐	Artificial Joints or Prosthesis
☐	☐	Pregnant Due Date: _____
☐	☐	Sinus Problems
☐	☐	Eye Infection
☐	☐	Diabetes
☐	☐	Asthma/Hay Fever
☐	☐	Hepatitis
☐	☐	AIDS or HIV Positive
☐	☐	Tuberculosis
☐	☐	Chemo/Radiation Therapy
☐	☐	Immunosuppressive Disease or TX.
☐	☐	Osteoporosis/Bisphosphonates

Medications (Give name, dosage. Include over-the-counter medications.)

Do you take Aspirin daily? ☐ yes ☐ no _____mg/per day

Chronic Problems

Therapies/Treatments

Hospitalizations and Operations

Dental Related Allergies (i.e., local anesthesia, antibiotics, pain medications, latex)

Has the doctor told you to take antibiotics before dental visits? ☐ yes ☐ no

Is there any other relevant medical/dental information we should know:

☐ Please X here if there is something in your medical history you would like to discuss privately with the doctor.

Dental History

The tooth:

☐ is hot or cold sensitive
☐ hurts to bite on
☐ wakes me up at night
☐ requires pain medication
☐ has a broken filling or has been traumatized

Has hurt about: ☐ 1-3 days ☐ 1-2 weeks ☐ 1 month or more

I understand that I have certain rights to privacy regarding my personal and health related information as provided by the Health Insurance Portability and Accountability Act 1996 (HIPAA). I have been given the opportunity to review and secure a more complete copy of this document. I understand by giving this consent, I authorize you to use and disclose my protected health information as needed for treatment, disclosure to other related health professionals, obtaining payment from 3rd party payers (i.e.: insurance companies) and sharing information with your family members as needed, including leaving messages on your phone and mailings to your phone and/or email address.

We will try to estimate your insurance coverage and ask you to pay the difference. However, due to the complexity of dental insurance, this is only an estimate and you may be responsible for more than suggested. Should any unpaid fees be turned over for collection, all costs, including reasonable collection fees, attorney fees and court costs incurred by Endodontic Specialists, PC shall be borne by the undersigned.

_____ _____ _____

Patient Signature (Parent or Guardian) | Date | Reviewed By (Office Use Only)