PATIENT REGISTRATION

Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have any questions regarding your care, appointments, or fees, please feel free to ask.

Name	Sex ___Male ___Female	Birthdate	Marital Status M D S W	Today's Date
Address (Street, P.O. Box, City, State, Zip)				
Patient's SS #	Patient's Drivers License#		Home Phone #	
Employer	Address (Street, P.O. Box, City, State, Zip)			Office Phone #
Legal Guardian (if Minor)		D.O.B.	Relationship to Patient	
Address (if different from Patient)			Phone #	
IN CASE OF EMERGENCY Notify		Relationship to Patient		Phone #
Referred By Whom				Phone #
Dentist	Address (Street, P.O. Box, City, State, Zip)		Phone #	
Physician	Address (Street, P.O. Box, City, State, Zip)		Phone #	

INFORMATION CONSENT: I understand that root canal treatment is a procedure to retain a tooth which may otherwise require extraction. There is a high degree of clinical success, but it is still biological treatment, so it cannot be guaranteed. Occasionally a tooth which has had root canal treatment may require treatment, surgery, or extraction. I also understand that only the root canal treatment will be performed in this office. The permanent restoration (filling or crown) will be done by my own dentist. Breakage of root canal instruments or perforation may occur. Tooth loss may occur due to progressive periodontal (gum) disease.
Permission is granted to communicate with attorneys/insurance companies regarding treatment.
A charge of 1½% per month will be charged on all accounts thirty days past due. Each account is due when services are rendered.
In the event costs are incurred or a suit is instituted to collect on this account, due to Patient's default, the Patient agrees and understands to pay all costs of collection.
Payments will be made by: (check one) ❑ **Charge Cards** ❑ **Cash** ❑ **Check**
The above information is true and accurate to the best of my knowledge.

Signed: _____

OVER

HEALTH HISTORY

FORM 044288 R/07/17 ITEM 8101

Information about your health will be held as confidential by this office and will be released only upon your expressed consent. Many general health factors may affect oral health and influence your care.

DOES YOUR PHYSICIAN REQUIRE YOU TO PRE-MEDICATE PRIOR TO DENTAL APPTS.?	Y	N
Name of Medication _____		
HAVE YOU EVER HAD:		
Rheumatic Fever		
Stroke		
Heart Trouble/Disease (i.e. MVP, By-Pass, etc.)		
Prosthesis (i.e. Hip, Knee Replacement, etc.)		
Hepatitis		
A		
B		
C		
Venereal Disease		
Liver Disease		
Tuberculosis		
Lung Problems		
Asthma		
Use Inhaler		
Shortness of Breath		
High Blood Pressure		
Low Blood Pressure		
Chest Pains		
Epilepsy/Seizures/Fainting		
Kidney Disease		
Diabetes		
Drug/Alcohol Abuse		

HAVE YOU EVER HAD:	Y	N
HIV Positive		
MERSA (MRSA)?		
Surgery		
Glaucoma		
Prostate trouble		
Psychiatric care		
Thyroid disease		
Ulcers/Colitis		
Headaches? Severe/Frequent		
TMJ Problems		
Sinus Problems/Allergies		
Cancer/Chemotherapy/Radiation		
Root Canal therapy		
AN UNFAVORABLE REACTION TO:		
Aspirin		
Anesthetics		
Barbiturates		
Penicillin		
Iodine		
Sulfa		
Novocaine		
Local Anesthetics		
Latex		
Other: _____		
ARE YOU:		
Taking bisphosphonates?		
Such as: Aredia, Zometa, Fosamax, Actonel, Skelid, Didronel, Boniva, Ibandronate, Reclast...		

ARE YOU:	Y	N
Taking any medication now		
Or within the past year		
Such as: Tranquilizers		
Nitrogylcerin		
Heart Pills		
Blood Pressure Pills		
Blood Thinners		
Insulin, orinase		
Antibiotics		
Steroids		
Presently under the care of a physician?		
Have you ever had problems getting numb?		
Have you had any serious problems with dental care?		
Have you ever had prolonged bleeding after surgery, trauma, or tooth removal?		
Have you ever had nitrous oxide?		
Have you ever had surgery/radiation treatment for a tumor, growth or other condition of your mouth or lips?		
If FEMALE, are you pregnant? week # _____		
Are you nursing?		
Do you have any disease or problem not listed above that you think we should know about?		
If so, what? _____		

Current medication you are taking now (name and strength) _____

NOTES: _____

SIGNATURE OF PATIENT (PARENT OR GUARDIAN) _____

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