PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Sex: Male Female

Address: _____ Apt #: _____ City, State, Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____ Marital Status:_____

Birth Date: _____ SSN: _____ General Dentist: _____

Employer: _____ Email address: _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

RESPONSIBLE PARTY – FILL IN THIS SECTION ONLY IF PATIENT IS A MINOR

Last Name: _____ First Name: _____ MI: _____ Sex: Male Female

Address: _____ Apt #: _____ City, State, Zip: _____

Phone #: _____ Birth Date: _____ SSN: _____

PRIMARY DENTAL INSURANCE HOLDER Self Spouse Parent Partner/Other SSN or MEMBER ID: _____

Last Name: _____ First Name: _____ MI: _____ Birth Date: _____

Employer: _____ Insurance Company: _____ Group #: _____

SECONDARY DENTAL INSURANCE HOLDER Self Spouse Parent Partner/Other SSN or MEMBER ID: _____

Last Name: _____ First Name: _____ MI: _____ Birth Date: _____

Employer: _____ Insurance Company: _____ Group #: _____

MEDICAL HISTORY

Are you under a physician's care now? ☐ YES ☐ NO If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ YES ☐ NO If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ YES ☐ NO If yes, please explain: _____

Are you taking or have you taken bisphosphonates? ☐ YES ☐ NO If yes, please list: _____ ☐ oral ☐ IV

Are you taking any medications, pills, or drugs? ☐ YES ☐ NO If yes, please list: _____

Do you take, or have you ever taken, Phen-Fen or Redux? ☐ YES ☐ NO

Are you on a special diet? ☐ YES ☐ NO

Do you use tobacco? ☐ YES ☐ NO

Do you PREMEDICATE for dental appointments? ☐ YES ☐ NO

Are you pregnant or breast feeding? ☐ YES ☐ NO

Are you allergic or sensitive to NOVACAINE, PENICILLIN, IBUPROFEN, ASPIRIN, ACETAMINOPHEN (TYLENOL), SULFA, TETRACYCLINE, CODEINE, LATEX, PABA OR OTHER MEDICATIONS? YES ☐ NO ☐ PLEASE LIST: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Alzheimer's Disease	☐ Anaphylaxis	☐ Anemia	☐ Angina
☐ Arthritis/Gout	☐ Artificial Heart Valve	☐ Artificial Joint	☐ Asthma	☐ Blood Disease
☐ Blood Transfusion	☐ Breathing Problems	☐ Bruise Easily	☐ Cancer	☐ Chemotherapy
☐ Chest Pains	☐ Cold Sores / Fever Blisters	☐ Congenital Heart Disorder	☐ Convulsions	☐ Cortisone Medicine
☐ Diabetes	☐ Drug Addiction	☐ Easily Winded	☐ Emphysema	☐ Epilepsy or Seizures
☐ Excessive Bleeding	☐ Excessive Thirst	☐ FaintingSpells / Dizziness	☐ Frequent Cough	☐ Frequent Diarrhea
☐ Frequent Headaches	☐ Genital Herpes	☐ Glaucoma	☐ Hay Fever	☐ Heart Attack/Failure
☐ Heart Murmur	☐ Heart Pace Maker	☐ Heart Trouble/Disease	☐ Hemophilia	☐ Hepatitis A
☐ Hepatitis B or C	☐ Herpes	☐ High Blood Pressure	☐ High Cholesterol	☐ Hives or Rash
☐ Hypoglycemia	☐ Irregular Heartbeat	☐ Kidney Problems	☐ Leukemia	☐ Liver Disease
☐ Low Blood Pressure	☐ Lung Disease	☐ Methemoglobinemia	☐ Mitral Valve Prolapse	☐ Osteoporosis
☐ Pain in Jaw Joints	☐ Parathyroid Disease	☐ Psychiatric Care	☐ Radiation Treatments	☐ Recent Weight Loss
☐ Renal Dialysis	☐ Rheumatic Fever	☐ Rheumatism	☐ Scarlet Fever	☐ Shingles
☐ Sickle Cell Disease	☐ Sinus Trouble	☐ Spina Bifida	☐ Stomach/Intestinal Disease	☐ Stroke
☐ Swelling of Limbs	☐ Thyroid Disease	☐ Tonsillitis	☐ Tuberculosis	☐ Tumors or Growths
☐ Ulcers	☐ Venereal Disease	☐ Yellow Jaundice		

Have you ever had any serious illness not listed above? ☐ YES ☐ NO If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I acknowledge full responsibility for the payment of services and agree to pay for them in full, by or before the completion of these services. If applicable, I hereby authorize payment directly to Contemporary Endodontics of the group insurance benefits otherwise payable to me. By giving my email address, I consent to electronic correspondence regarding treatment or appointments from Contemporary Endodontics.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____