PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____ Marital Status:_____ Sex: Male Female Other

Street Address: _____ Apt #: _____

City, State, Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

Email address: _____

General Dentist: _____ Office Location: _____

Pharmacy Name & Intersection: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone #: _____ Relationship: _____

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

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____ Relationship: _____

Sex: Male Female Other Preferred Contact Phone #: _____

Street Address: _____ Apt #: _____

City, State, Zip: _____

PRIMARY DENTAL INSURANCE HOLDER Self Spouse Parent Partner/Other

Last Name: _____ First Name: _____

Birth Date: _____ SSN or MEMBER ID: _____ Group #: _____

Employer: _____ Insurance Company: _____

SECONDARY DENTAL INSURANCE HOLDER Self Spouse Parent Partner/Other

Last Name: _____ First Name: _____

Birth Date: _____ SSN or MEMBER ID: _____ Group #: _____

Employer: _____ Insurance Company: _____

DENTAL INFORMATION

Do your gums bleed when you brush or have you had any periodontal (gum) treatments? □ YES □ NO
Have you ever had orthodontic treatment (braces)? □ YES □ NO
Do you wear a removable dental appliance? □ YES □ NO
Have you had any serious trouble associated with any previous dental treatment? □ YES □ NO
If yes, please specify _____
Have you had head, neck, or jaw injuries or do you have ear aches or neck pain? □ YES □ NO
If yes, please specify _____
Do you have or have you been diagnosed or treated for temporomandibular joint (TMJ) problems? □ YES □ NO

MEDICAL INFROMATION

Are you in good health? □ YES □ NO
Has there been any change in your general health within the past year? □ YES □ NO
If yes, please specify _____
Are you under the care of a physician? □ YES □ NO Physician name and phone number _____
Have you had a serious illness, operation, or been hospitalized within the last five years? □ YES □ NO
If yes, please specify _____
Are you taking any prescription medications, over the counter medications, vitamins or supplements? □ YES □ NO
Please list:

_____

(CONTINUED ON BACK PAGE)

Have you ever taken, Phen-Fen or Redux, for weight loss? ☐ YES ☐ NO Are you on a special diet? ☐ YES ☐ NO
Do you use alcohol, drugs, or other substances recreationally? ☐ YES ☐ NO Have you ever received treatment for substance abuse? ☐ YES ☐ NO
Do you use tobacco? ☐ YES ☐ NO Do you use an e-cigarette or vaping products? ☐ YES ☐ NO

Are you ALLERGIC to or have you had a reaction to any medications, metals, or latex? ☐ YES ☐ NO
Please list:

_____

Have you ever had joint replacement surgery? ☐ YES ☐ NO Which joint(s)? _____
When was operation done? _____ Any complications? ☐ YES ☐ NO
Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? ☐ YES ☐ NO

WOMEN ONLY ☐ Possibility of pregnancy, estimated due date _____ ☐ Nursing ☐ Taking birth control pills

Please mark box if you have, or have had, any of the following

☐ Abnormal Bleeding
☐ AIDS or HIV Infection
☐ Anemia/Blood Disorder
☐ Arthritis
☐ Rheumatoid Arthritis
☐ Asthma
☐ Blood Transfusion Date _____
☐ Bruise Easily
☐ Cancer ☐ Chemotherapy ☐ Radiation
☐ Cardiovascular Disease (please specify below)
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Artificial Heart Valve
- ☐ Congenital Heart Failure
- ☐ Congestive Heart Failure
- ☐ Coronary Heart Failure
- ☐ Coronary Artery Disease
- ☐ Damaged Heart Valve
- ☐ Heart Attack
- ☐ Irregular Heartbeat
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker / Defibrillator
- ☐ Rheumatic Fever

☐ Chest Pain Upon Exertion
☐ Chronic Pain
☐ Contagious Diseases
☐ Immunosuppression
☐ Diabetes ☐ Type I (Insulin Dependent) ☐ Type II
☐ Dry Mouth
☐ Eating Disorders
Please specify

_____

☐ Epilepsy
☐ Fainting Spells or Seizures
☐ Gastrointestinal Disease
☐ GE Reflux / Persistent Heartburn
☐ Glaucoma / Eye Disease
☐ Healing Delay
☐ Hemophilia
☐ Hepatitis ☐ A ☐ B ☐ C ☐ Jaundice or Liver Disease
☐ Recurrent Infections
Please specify

_____

☐ Kidney Problems ☐ Dialysis
☐ Low Blood Sugar
☐ Mental Health Disorders
☐ Malnutrition
☐ Night Sweats ☐ Chronic Fatigue
☐ Neurological Disorder
Please specify

_____

☐ Osteoporosis ☐ Taking or have taken Bisphosphonates
Please specify

_____

☐ Persistent Swollen Glands in Neck
☐ Respiratory Problems ☐ Emphysema ☐ Bronchitis
☐ Severe Headaches / Migraines
☐ Severe or Rapid Weight Loss
☐ Sexually Transmitted Disease
☐ Sinus Trouble
☐ Sleep Disorder
☐ Sores or Ulcers in Mouth
☐ Stroke
☐ Systemic Lupus Erythematosus
☐ Tuberculosis
☐ Ulcers / Colitis
☐ Excessive Urination
☐ Any disease, condition or problem not listed above
Please specify

_____

_____

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 for the 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 OR PARENT OR GUARDIAN_____

DATE _____