ENDODONTICS

Patient Registration

Patient ______________________ Birth Date: __________
First   Middle Initial   Last
SS#: __________ Sex ❑ F ❑ M

Mailing Address Street: ______________________
City: __________ State: ______ Zip Code: __________

Phone Numbers Home Phone: (   ) __________ Cell Phone: (   ) __________

Email Address ______________________

If patient is a minor, who is legally responsible? (Guardian) ______________________

DOB __________ Relationship __________

In case of emergency, who should we contact? ______________________

Phone: (   ) __________ Relationship: __________

Referring Dentist: ______________________

Preferred Pharmacy __________ Phone __________

DENTAL INSURANCE INFORMATION

Is treatment covered by insurance? ❑ Yes ❑ No

Name of Insurance Company: __________ Phone Number: __________

Insurance Address: ______________________

Subscriber's Name: __________ ID Number: __________

Birth Date: __________ Patient's Relationship to the Subscriber: __________

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

Is patient covered by additional insurance? ❑ Yes ❑ No

Name of Secondary Insurance Company: __________ Phone Number: __________

Insurance Address: ______________________

Subscriber's Name: __________ ID Number: __________

Birth Date: __________ Patient's Relationship to the Subscriber: __________

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

HEALTH HISTORY

Name of Physician: __________ Phone Number: __________

Are you in good health?.................................... ❑ Yes ❑ No

Are you presently under the care of a physician?... ❑ Yes ❑ No Date of your last physical exam: __________

If yes, for what condition(s)? ______________________

In the last five years, have you ever been: (If yes, please explain)

a. Hospitalized? ❑ Yes ❑ No __________
b. Had a serious illness? ❑ Yes ❑ No __________
c. Had a major operation? ❑ Yes ❑ No __________

(over)

Have you had, or do you presently have any of the following conditions?
If there are multiple options, please **circle condition.**

	YES	NO
Heart surgery, disease or attack	❑	❑
Angina Pectoris/Chest pain	❑	❑
High/Low blood pressure	❑	❑
Heart murmur	❑	❑
Rheumatic Fever (Rheumatic Heart Disease)	❑	❑
Congenital heart lesions (Mitral Valve Prolapse)	❑	❑
Artificial heart valve	❑	❑
Heart pacemaker	❑	❑
Artificial joint/Prosthesis	❑	❑
Stroke	❑	❑
Kidney disease	❑	❑
Cancer or tumors	❑	❑
Thyroid disease	❑	❑
Lung disease/Tuberculosis	❑	❑
Diabetes	❑	❑
Jaw joint (TMJ) problems	❑	❑
Surgery or x-ray treatment for a tumor, growth or other condition of the head, mouth or lips	❑	❑
AIDS or HIV positive	❑	❑
Hepatitis, jaundice or liver disease	❑	❑
Blood transfusion	❑	❑
Drug addiciton/Alcholism	❑	❑
Hemophilia or excessive bleeding	❑	❑
Sexually transmitted disease	❑	❑
Cold sores	❑	❑
Herpes	❑	❑
Psychiatric treatment/Mental disorders	❑	❑
Allergies	❑	❑
Asthma/Hay Fever	❑	❑
Sinus trouble	❑	❑
Seizures/Epilepsy	❑	❑
Arthritis	❑	❑

Have you ever had an allergic or unusual reaction to any of the following?

	YES	NO
Dental local anesthetics	❑	❑
Aspirin or Ibuprofen (Advil)	❑	❑
Acetaminophen (Tylenol)	❑	❑
Barbiturates or Tranquilizers	❑	❑
Codeine or other narcotics	❑	❑
Latex materials	❑	❑
PENICILLIN	❑	❑
ERYTHROMYCIN or other antibiotics	❑	❑
Sulfa drugs	❑	❑
Any other medications or drugs?	❑	❑

(Which ones)? ______________________

Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel®, Fosamax®, or Zometa, within the past twelve years? ❑ ❑

WOMEN: Are you pregnant? ❑ ❑ If yes, how many months?__________

Are you breast feeding? ❑ ❑ Are you taking birth control pills?* ❑ ❑

***(If you ARE taking birth control pills, please read the following:** Antibiotics may inactivate birth control medication. Therefore, if you need to take antibiotics during endodontic treatment, additional birth control methods should be used until your next menses).

Please list any medications, over the counter or prescription, that you are now taking:

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If you have ever had any serious complications involving dental treatment, please explain: ______________________

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Please comment on any "YES" answers above, or feel free to add any information regarding your medical history that may not have been mentioned: ______________________

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I authorize release of any information relating to this claim. I hereby authorize payment of the dental benefits directly to Dr. Stephen Ottosen and Dr. Kevin Nygard

Patient Signature: ______________________ Date: ______________
(Parent or Guardian if patient is a minor)