PATIENT REGISTRATION FORM

❑ Male ❑ Female

NAME (Title, First Name, MI & Last Name) | NICKNAME | BIRTHDATE

ADDRESS (Street & Apt #) | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | WORK PHONE | EMAIL

SOCIAL SECURITY NUMBER | GENERAL DENTIST | REFERRED BY

EMERGENCY CONTACT | PHONE | NAME OF SPOUSE/SIGNIFICANT OTHER

PREFERRED PHARMACY | CROSS STREETS

How did you hear about us? ❑ Dentist ❑ Friend ❑ Internet/Social Media ❑ Other ____________

Please check yes (Y) or no (N) for all conditions (past or present).

Y N		Y N		Y N		Y N	
❑ ❑	High Blood Pressure	❑ ❑	Cardiac Transplant	❑ ❑	Diabetes	❑ ❑	HIV Positive
❑ ❑	Congenital Heart Defects	❑ ❑	Angina Pectoris	❑ ❑	Thyroid Condition	❑ ❑	Drug Addiction
❑ ❑	Artificial Heart Valve	❑ ❑	Heart Attack/Stroke (CIRCLE)	❑ ❑	Bleeding Disorders		OTHER
❑ ❑	Infective Endocarditis	❑ ❑	Epilepsy/Seizures (CIRCLE)	❑ ❑	Tuberculosis		____________
❑ ❑	Heart Surgery	❑ ❑	Pain in Jaw Joint	❑ ❑	Hepatitis A, B or C (CIRCLE)		____________

List medications you are currently taking:

	Yes	No	
Have you ever had an unusual reaction to latex, anesthetics, or drugs such as penicillin, codeine, aspirin, sulfa, or any other medications?	❑	❑	If yes, please explain:
Have you ever taken bisphosphonates (osteoporosis medication)?	❑	❑	If yes, ❑ In the Past or ❑ Presently Please list:
Are you currently taking a blood thinner?	❑	❑	If yes, please list:
Are you able to take ibuprofen?	❑	❑	
Are you required to take antibiotic premedication **1 hour prior** to dental appointments?	❑	❑	If yes, list reason and name of antibiotic:
Women: Are you pregnant?	❑	❑	If yes, how far along:

How are you feeling today?

❑ Confident

❑ Happy

❑ Curious

❑ Pained

❑ Anxious

❑ Frightened

CONTINUE ▶

Primary Dental Insurance

POLICY HOLDER NAME | BIRTHDATE | SOCIAL SECURITY NUMBER

RELATIONSHIP TO PATIENT | Is patient a full-time student: ❑ Yes ❑ No | SCHOOL

INSURANCE COMPANY | MEMBER ID | GROUP # | INSURANCE PHONE

EMPLOYER | LENGTH OF EMPLOYMENT | EMPLOYER ADDRESS

Secondary Dental Insurance

POLICY HOLDER NAME | BIRTHDATE | SOCIAL SECURITY NUMBER

RELATIONSHIP TO PATIENT

INSURANCE COMPANY | MEMBER ID | GROUP # | INSURANCE PHONE

EMPLOYER | LENGTH OF EMPLOYMENT | EMPLOYER ADDRESS

Complete only if patient is a minor

RESPONSIBLE PARTY | BIRTHDATE | RELATIONSHIP TO PATIENT

❑ Same address and contact as minor

ADDRESS (Street & Apt #) | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | WORK PHONE | EMAIL

The purpose of **Endodontic treatment** (root canal therapy) is to save your tooth rather than remove it. Although this treatment has a high rate of success, it cannot be guaranteed. A tooth that has had root canal treatment may require re-treatment, surgery or eventual extraction. Before any treatment is started, the reason(s) will be explained as well as alternative modes of therapy. Occasionally, an antibiotic may be indicated. This will be discussed in advance.

After treatment you must return to your general dentist to have your tooth restored with a permanent filling or crown. Fees incurred in another office are not included in our costs.

- I consent to necessary treatment and authorize the release of any information needed for continued care.
- I authorize the release of information to my insurance company & payment of benefits directly to provider. Any balance not paid by my insurance will be due within two weeks of the statement date.
- I am financially responsible for fees incurred at the time of service. In the event my account becomes delinquent, I understand a **LATE FEE** up to **$10** and/or a **SIMPLE INTEREST CHARGE** will be added to the account. The **INTEREST CHARGE** will be at a periodic rate of **1.5%** per month, which is an **ANNUAL PERCENTAGE RATE** of **18%**, applied to the last month's balance. Also, an additional **30%** of the principal balance due will be added to help cover the cost of collection. I understand that I am responsible for attorney's fees, interest and court costs, should it become necessary that legal action be taken, and that a credit report will be obtained for the sole purpose of collecting a delinquent balance.

Signature of patient (Parent/Guardian of minor) | Date