PATIENT REGISTRATION

Name _____ Date _____
Street _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____ Age ____ Sex ____
Employed By _____ Date of Birth _____ SS # _____
Employer's Address _____ Occupation _____
Referring Dentist _____ Physician _____
Emergency Contact: Name _____ Phone # _____

PERSON RESPONSIBLE FOR PAYMENT (If other than patient)

Name _____ Home Phone _____
Address _____ Business Phone _____
Occupation _____ SS # _____
Employed By _____
Employer's Address _____
Relationship to Patient _____

DENTAL INSURANCE INFORMATION

Ins. Co. Name _____ Insured Employee Name _____
Employer _____ Group # _____
If accident, date _____ Describe _____
SS # _____ Date of Birth _____ If Aetna/Cigna ID# _____

HEALTH QUESTIONS

1. Is your health good? ❑ Yes ❑ No
2. Are you under a physician's care now? ❑ Yes ❑ No
3. Have you ever had ...

Heart Trouble	❑ Yes	❑ No	Sinus Problems	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Fainting	❑ Yes	❑ No	Asthma	❑ Yes	❑ No
Bleeding Problems	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Allergies	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No	Arthritis	❑ Yes	❑ No	Ulcer	❑ Yes	❑ No
Venerial Disease	❑ Yes	❑ No	Anemia	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Tested HIV+	❑ Yes	❑ No	Other	❑ _____		Other	❑ _____	

Bleach ___Y ___N
Latex ___Y ___N
Anesthetic ___Y ___N

4. Are you allergic to or unable to eat bananas, avocados, chestnuts, kiwis, tomatoes, potatoes and hazelnuts? ❑ Yes ❑ No
5. Do you have a history of surgery, especially, several repeated procedures in childhood? ❑ Yes ❑ No
6. Do you have Spina Bifida? ❑ Yes ❑ No
7. Repeated urinary catherization? ❑ Yes ❑ No
8. Can you blow up balloons? ❑ Yes ❑ No
9. Do you have a heavy, persistent cough of 2-3 weeks duration, particularly one that brings up sputum or bloodied sputum? ❑ Yes ❑ No
10. Do you wake up multiple times at night to change your clothes and bedding because they are unusually saturated with perspiration? ❑ Yes ❑ No
11. Have you ever had a reaction to:
    Novocaine ❑ Yes ❑ No. Codeine ❑ Yes ❑ No. Penicillin ❑ Yes ❑ No. Aspirin ❑ Yes ❑ No.
12. Are you presently taking any medication (drugs)? ❑ Yes ❑ No If so, please list _____
13. Women, are you pregnant? ❑ Yes ❑ No
14. Is there any other information about your health we should know? ❑ Yes ❑ No _____

I certify (to the best of my knowledge) that the above information is correct. I grant permission to release any health and/or dental information to my insurance company. I also grant permission to communicate with my medical doctor concerning my health status.

I understand that only the root canal treatment will be done at this office. The permanent restoration (filling, inlay, crown, etc.) will be completed by my regular dentist.

Patient Signature _____ Parental Permission _____