PATIENT REGISTRATION

First Name	Middle Int	Last	Preferred	Sex M F	Birth Date	Social Security #
Street Address			City	State	Zip	Cell Phone
Employer		Occupation		Work Phone		Email

SPOUSE INFORMATION

Name	Birth Date	Social Security #	Cell Phone
Employer	Occupation	Home Phone	Email

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Name of person responsible for bill		Relationship to Patient		Birth Date	Social Security #
Street Address	City	State	Zip	Home Phone	Cell Phone
Employer		Occupation			

GENERAL INFORMATION

Your Dentist Name	Phone	City
Your Physician Name	Phone	City
Emergency Contact	Phone	Relationship

DENTAL INSURANCE INFORMATION

Primary Coverage - Name of Insurance Company		Secondary Coverage - Name of Insurance Company	
Subscriber	Birthdate	Subscriber	Birth Date
Group #	Subscriber ID #	Group #	Subscriber ID #
Claims Address	Phone #	Claims Address	Phone #

ASSIGNMENTS

I authorize payment directly to Endodontics Northwest for benefits they are entitled to under my dental/medical insurance plans. I understand I am responsible for any unpaid balance on my account once insurance has paid to a deductible, annual maxi mum or allowance for any procedure.

We will make every effort to keep you informed of the treatment outlined for you. Your involvement and understanding are very important in the long term success of your endodontic therapy.

TURN OVER ▶

MEDICAL HISTORY

Although some of the following questions may seem unrelated to your oral health, they are associated with proper management of your oral health and are confidential.

Are you sensitive, allergic to or nauseated by any of the following medications:

❒ Penicillin ❒ Ibuprofen ❒ Latex ❒ Codeine ❒ Dental Anesthetic ❒ Other (below)

List other drugs or substances you may be allergic to: _____

List any medications you are currently taking or have taken in the past year:

Medication Name	Dose	

Over-the-counter: _____

Do you need antibiotic Premedication before Dental treatment? ❒ Yes ❒ No

Please check any that apply:

If all answers below are 'no' please check here ❒

❒ Hepatitis
❒ Jaundice
❒ Epilepsy
❒ Arthritis
❒ Rheumatic Fever
❒ Anemia or Blood Disorders
❒ Diabetes
❒ Heart murmur
❒ Stroke
❒ Chest pains
❒ High blood pressure
❒ Low blood pressure
❒ Prolonged bleeding
❒ Radiation treatment
❒ Cancer
❒ Kidney Disease
❒ Fibromyalgia
❒ Stomach or Duodenal Ulcer
❒ Liver Disease
❒ Tuberculosis
❒ A tumor or abnormal growth
❒ Emphysema ❒ Glaucoma
❒ Pace Maker
❒ Sleep Apnea
❒ Shortness of breath
❒ Hives, skin rash, hay fever
❒ Asthma
❒ Psychiatric treatment
❒ HIV or AIDS
❒ Thyroid or parathyroid disorder
❒ Heart Attack

Are you:

❒ Presently being treated for any illness or disease?
❒ Taking Aspirin each day? If so, how many mg? _____
❒ Aware of a change in your general health in the past year?
❒ Often exhausted and fatigued?
❒ Subject to frequent headaches?
❒ Do you use tobacco in any form? Y / N Type: _____

If you are female, are you:

❒ Pregnant or breast feeding?
❒ Taking birth control or other hormones?

Do you NOW or have you IN THE PAST taken Bisphosphonates (marketed as Actonel, Actonel+Ca, Aredia, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid and Zometa)? ❒ Yes ❒ No If yes, when? _____ For how long? _____

Have you been hospitalized for any illness or surgery? _____

To the best of my knowledge the above information is correct and accurate.

Patient's Signature _____ If Patient is a Minor, Signature of Parent or Guardian _____ Date _____