All County Endodontics, PC Microsurgical Center

Patient Registration and Health Form

Circle Title: Mr. Ms. Mrs. Dr. Other:_____

Name: _____
First M.I. Last

Address:_____
Street City State Zip

Gender (circle): F M Date of Birth: / / SSN: - -

Home Phone:_____ Cell Phone: _____

Who will pay this account? _____

Name and address of dental insurance company: _____

Name of policy holder: _____ DOB: / / SSN:_____

Policy #: _____ Group #: _____

Name of policy holder's employer: _____

General Dentist: _____ Referred by: _____
(first and last name) (please write "same" if referred by dentist)

In case of emergency, contact: _____ Phone: _____

Please fill out the following health history to the best of your knowledge. All patient information is confidential. Although endodontists primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the care that you will be receiving. Your answers are for our records only and are confidential.

Do you have any health conditions of which the doctors should be aware?	Yes	No
Were there any changes in your general health in the past year?	Yes	No
Are you under the care of a physician?	Yes	No
If so, for what are you being treated? _____		
Date of last medical examination: _____		
Have you had any illness, surgery, or been hospitalized in the past 5 years?	Yes	No
Do you have any unhealed injuries, inflamed areas, growths in or around your mouth? If so, please describe: _____	Yes	No
Do you have a prosthetic joint?	Yes	No
If so, please describe where and when (month/year): _____		
Do you have a heart valve replacement or congenital heart defect?	Yes	No

Have you had, or do you currently have any of the following?

Subacute bacterial endocarditis	Yes	No	Emphysema	Yes	No
Damaged heart valves	Yes	No	Tuberculosis	Yes	No
Mitral valve prolapse	Yes	No	Blood disorders (anemia, etc)	Yes	No
Heart murmur	Yes	No	Bruise easily	Yes	No
Rheumatic fever	Yes	No	Jaundice/Hepatitis/Liver		
Rheumatic heart disease	Yes	No	disease	Yes	No
High blood pressure	Yes	No	Stomach ulcers	Yes	No
Low blood pressure	Yes	No	Irritable bowel disorder	Yes	No
Chest pain, angina	Yes	No	Sexually transmitted disease	Yes	No
Stroke	Yes	No	HIV/AIDS	Yes	No
Thyroid trouble	Yes	No	Immune system problems	Yes	No
Diabetes / Low blood sugar	Yes	No	Delay in healing	Yes	No
Kidney trouble / Dialysis	Yes	No	Tumor or growth	Yes	No
Heart attack	Yes	No	Radiation/Chemotherapy	Yes	No
Irregular heart beat	Yes	No	Eye disease/Glaucoma	Yes	No
Cardiac pacemaker	Yes	No	Seizure/Epilepsy	Yes	No
Heart surgery	Yes	No	Malignant hyperthermia	Yes	No
Bronchitis / Chronic cough	Yes	No	History of drug abuse	Yes	No
Asthma	Yes	No	Osteoporosis	Yes	No
Difficulty breathing	Yes	No			
TMJ/TMD (temporomandibular joint/temporomandibular dysfunction)				Yes	No

Have you ever been required to take antibiotics prior to dental treatment? Yes No
If so, for what reason? _____
Have you ever had administered intravenous bisphosphonate medications, such as Zometa or Aredia, or taken orally Boniva, Actonel, or Fosamax? (Please circle which) Yes No

Please list all medicine, drugs, pills, over the counter medications you are taking:

Allergies: Are you allergic to or had a reaction to any of the following? (Please circle)

Local anesthetics (lidocaine, etc)	Yes	No	Aspirin	Yes	No
Penicillin	Yes	No	Codeine	Yes	No
Other antibiotics	Yes	No	Other narcotics	Yes	No
Latex	Yes	No	Other: _____		

Women:

Are you pregnant?	Yes	No	If yes, estimated delivery date: _____
Are you nursing?	Yes	No	

**Please note that any antibiotics, such as penicillin, may alter the effectiveness of birth control pills*

Our privacy policy: Your personal privacy is important to us; we can provide you with our comprehensive "Notice of Privacy Practices" if you request. By signing below you authorize our office to use your protected personal information which includes the chart data, x-rays, and any forms for the proper diagnosis and treatment of your condition, and for billing of insurance, if applicable. The authorization remains in effect as long as treatment services are rendered to you. You may inspect this information, revoke this authorization in writing, or refuse the authorization by non signing below.

Patient Signature: _____ Date: _____ Dr's initial: _____