PATIENT REGISTRATION

Field ENDODONTICS

Date _____

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

Patient's Name _____ Sex ☐ M ☐ F

Name You Want To Be Called By Our Staff _____

Primary Contact Phone # _____ Second Contact Phone # _____

Patient's Address _____
Street City Zip

DL# _____ Birthdate _____

Patient's Employer _____ Business Address _____

Occupation _____ Whom May We Thank For Referring You _____

Emergency Contact Name & Phone # _____

PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR AND / OR RESPONSIBLE PARTY

You are the child's: ☐ Parent ☐ Legal Guardian ☐ Other _____

Responsible Party's Complete Name _____ Social Security Number _____

Home Address _____ Phone (Primary) _____ (Secondary) _____
Street City Zip

DL# _____ Place Of Employment _____ Occupation _____

Business Address _____ Phone (Business) _____
Street City Zip

MEDICAL HISTORY

Are You In Good Health? ☐ Yes ☐ No ☐ Don't Know Height _____ Weight _____
(Required information by State of Texas)

Name of Physician _____ Last Complete Physical _____

Name And Address of Dentist _____

Are You Taking Any Medication Now? ☐ Yes ☐ No Please List _____

_____

_____

_____

_____

Are You Allergic To: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Injected Anesthetics ☐ Household Cleaning Products

☐ Latex ☐ Other: _____ ☐ No Known Drug Allergies

Do You Take Blood Thinners Or Are You Subject To Prolonged Bleeding? ☐ Yes ☐ No

(Women) Are You Pregnant Or Trying To Get Pregnant? ☐ Yes ☐ No Which Trimester? _____

Are You Nursing ☐ Yes ☐ No

Have You Had Any Serious Trouble Associated With Previous Dental Treatment? ☐ Yes ☐ No Explain _____

_____

_____

Please complete the reverse side of this form

Do You Have, Or Have You Had, Any Of The Following?:

Alzheimer's Disease	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Arthritis / Gout	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Autoimmune Disease	☐ Yes	☐ No	Mitral Valve Problems	☐ Yes	☐ No
AIDS / HIV Positive	☐ Yes	☐ No	Migraines	☐ Yes	☐ No
Bacteremia/Septicemia	☐ Yes	☐ No	Pain In Jaw Joints	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Cold Sores / Fever Blisters	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Stomach Disease	☐ Yes	☐ No
Electronic Implanted Device	☐ Yes	☐ No	Intestinal Disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Epilepsy Or Seizures	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Fainting Spells / Dizziness	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Heart Attack / Failure	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No			
Heart Pace Maker	☐ Yes	☐ No			
Heart Trouble / Disease	☐ Yes	☐ No			
Hemophilia	☐ Yes	☐ No			
Hepatitis A, B, Or C	☐ Yes	☐ No			
High Blood Pressure	☐ Yes	☐ No			
Hives Or Rash	☐ Yes	☐ No			

Any Other Illness: _____

_____

Past Surgeries: _____

_____

_____

_____

Signature: _____