Field Endodontics

PATIENT REGISTRATION

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

Patient's Name ______________________________ Sex ☐ M ☐ F

Today's Date ______________________________

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 ______________________________

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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/Trying To Get Pregnant? ☐ Yes ☐ No Trimester?_________ Nursing? ☐ Yes ☐ No

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

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Have Any Of Your Family Members Had Trouble With Surgeries Or Anesthesia? ☐ Yes ☐ No

Please complete the reverse side of this form

Do You <u>Have</u>, Or <u>Have You Had</u>, Any Of The Following?:

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

Any Other Illness or Health Issues: ____________________

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Past Surgeries: ______________________________

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Signature: ____