



PATIENT REGISTRATION

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 # _____

Patient's Address _____ Second Contact Phone # _____
Street City Zip

DL# _____ Social Security Number _____ Birthdate _____

Patient's Employer _____ Business Address _____

Occupation _____ Whom May We Thank For Referring You _____

Name Of Spouse _____ Spouse's Employer / Occupation _____

Emergency Contact Name & Phone # _____

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

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 And Address 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: _____

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	Pain In Jaw Joints.....	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
Blood Transfusion.....	☐ Yes	☐ No	Phychiatric 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	Sickel 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	Any Other Illness: _____		
Heart Pace Maker.....	☐ Yes	☐ No	_____		
Heart Trouble / Disease.....	☐ Yes	☐ No	_____		
Hemophilia.....	☐ Yes	☐ No	Past Surgeries: _____		
Hepatitis A, B, Or C	☐ Yes	☐ No	_____		
High Blood Pressure.....	☐ Yes	☐ No	_____		
Hives Or Rash	☐ Yes	☐ No	_____		

Signature: _____