METROPLEX ENDODONTICS & MICROSURGERY, P.A.

PATIENT REGISTRATION

SECTION A1: Patient Information

☐ Mr. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. Date _____

Patient's Name _____ Preferred Name_____ Sex ☐ M ☐ F

Birthdate _____ Home Address _____
Street City Zip

Is Patient 18 years of age or older? ☐ Yes ☐ No ***(If answer is NO, complete the rest of Section A-1 and skip all of Section A-2. If answer is YES, proceed on to Section A-2)***

Responsible Party's Complete Name _____ Sex ☐ M ☐ F

Birthdate _____ Home Address _____
Street City Zip

1st Best Contact Number (_____)_____ ☐ Cell ☐ Home ☐ Work
2nd Best Contact Number (_____)_____ ☐ Cell ☐ Home ☐ Work

DL # _____ SS# _____ Occupation _____

Place of Employment_____ Business Phone _____

SECTION A-2: Patient Information

1st Best Contact Number (_____)_____ ☐ Cell ☐ Home ☐ Work
2nd Best Contact Number (_____)_____ ☐ Cell ☐ Home ☐ Work

DL # _____ SS# _____ Occupation _____

Place of Employment_____ Business Phone _____

Name of Spouse _____ Spouse's Phone _____

Emergency Contact Person _____ Phone _____

SECTION B: Medical History

Patient's General Health Condition ☐ Excellent ☐ Good ☐ Fair ☐ Poor Height_____ Weight____
Name and Address of Physician _____
Name and Address of Dentist _____
Were you referred to us by your dentist? ☐ Yes ☐ No ***(If answer is NO, please indicate who referred you to us and their address: _____)***
Are You Taking Medication? ☐ Yes ☐ No ***(If answer is YES, please list all medications here:***

Are You Allergic To: ☐ Penicillin ☐ Codeine ☐ Local Injected Anesthetics ☐ Latex ☐ Other: _____

Are You Subject to Prolonged Bleeding? ☐ Yes ☐ No Are You Pregnant? ☐ Yes ☐ No

If Pregnant, Which Trimester? _____ Are You Nursing? ☐ Yes ☐ No

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

(If answer is YES, please explain: _____)

Check any of the following which you have had or have at present:

☐ Heart Disease or Attack	☐ Diabetes	☐ Arthritis
☐ Artificial Heart Valve	☐ Kidney Trouble	☐ Cortisone Medication or Injections
☐ Heart Pacemaker	☐ Asthma	☐ Ulcers (Stomach)
☐ Heart Surgery	☐ Shortness of Breath	☐ Glaucoma
☐ Heart Murmur/Mitral Valve	☐ Liver Disease	☐ Hemophilia
☐ High Blood Pressure	☐ Hepatitis B (Serum)	☐ Bruise Easily
☐ Rheumatic Fever	☐ Hepatitis A	☐ Epilepsy or Seizures
☐ Scarlet Fever	☐ Artificial Joint	☐ Drug Addiction
☐ Cancer or Tumor	☐ HIV Positive (AIDS)	☐ Psychiatric Treatment
☐ Chemotherapy (Cancer, Leukemia)	☐ Tuberculosis (TB)	☐ Nervousness
☐ Stroke	☐ Thyroid Disease	☐ Cold Sores or Fever Blisters

SECTION C: FINANCIAL INFORMATION

Payment is due upon services. Payment options include Check, Cash, Visa, Master Card, Discover, American Express, and CareCredit. If a patient has dental insurance, the patient must understand that they are responsible for any charges the insurance does not cover.

Endodontic Fees:

Examination…….$106	Anterior Root Canal…….. $1050-$1409
Radiograph……. $20	Bicuspid Root Canal…….. $1215-$1542
Nitrous Oxide……. $98	Molar Root Canal…….. $1395-$1723
Oral Sedation……. $223	Final Restoration Fee…….. $189-$584

Please note that fees are subject to change for the following reasons: restorations, obstruction removal, surgery, *failed appointments, and for any other problems which may become apparent before, during, or after treatment. *Our office charges a fee for all missed appointments with less than a 24-hours notice.

_____ _____ _____

Signature of Patient or Responsible Party Date Witness