METROPLEX ENDODONTICS & MICROSURGERY, P.A.
PATIENT REGISTRATION FORM

Title:_____ First Name:_____ MI:_____ Last Name:_____

Preferred Name:_____ Birthdate:_____ Age:_____ Soc. Sec. #:_____

Gender: Male_____ Female_____ Ht._____ Wt._____ Address:_____

Apt/Suite:_____ City:_____ State:_____ Zip Code:_____

Phones: Home:_____ Work:_____ Ext.:_____

Cell/Mobile:_____ Fax:_____ Occupation:_____

Email:_____ Spouse's Name/Work Ph. #:_____

Employer:_____ Employer's Address:_____

Referred By:_____ General Dentist:_____

Family Physician Name and Phone:_____ Type of medical Ins.:_____

Have you been seen in this practice before today? Yes_____ No_____

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient):

Title:_____ First Name:_____ MI:_____ Last Name:_____

DOB:_____ Relationship to Patient: _____ Spouse _____ Child _____ Other - Please specify _____

Soc. Sec. #:_____ Address:_____ Apt/Suite:_____

City:_____ State:_____ Zip Code:_____

Phones: Home:_____ Work:_____ Ext.:_____

Cell/Mobile:_____ Email:_____

Employer's Name:_____ Phone:_____

Occupation:_____

DENTAL INSURANCE INFORMATION:

Primary Insurance

Insurance Co._____

Address:_____

Group #:_____ Phone:_____

Employer:_____

Employee (if other than patient):

Name:_____

Address:_____

Birthdate:_____ Soc. Sec. #:_____

Phone:_____

Subscriber ID #:_____

Male_____ Female_____

Secondary Insurance

Insurance Co._____

Address:_____

Group #:_____ Phone:_____

Employer:_____

Employee (if other than patient):

Name:_____

Address:_____

Birthdate:_____ Soc. Sec. #:_____

Phone:_____

Subscriber ID #:_____

Male_____ Female_____

Your insurance is a contract between you and your insurance company. The financial obligations for treatment rendered to you are ultimately your responsibility: however, we will submit the charges to your insurance company as a courtesy to you. In the event that you do not receive the benefits you believe you are entitled, please contact YOUR insurance carrier and/or employee benefits representative.

I, the undersigned, have read and understand the above statement. I assign benefits to Metroplex Endodontics & Microsurgery, P.A.

X:_____ Patient/Guardian Signature _____ Date

IN CASE OF EMERGENCY, PLEASE NOTIFY: (other than spouse):

NAME:_____ RELATIONSHIP TO PATIENT:_____

Home Phone:_____ Work Phone:_____

Cell/Mobile Phone:_____ Pager Number:_____

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PATIENT REGISTRATION FORM

Title:_____ First Name:_____ MI:_____ Last Name:_____ Birthdate:_____

REASON FOR THIS VISIT? Please be specific

Is present problem due to an accidental injury? YES NO

How and When did the accident occur?_____

_____

In the following questions, circle YES or No, whichever applies.

1. **Has there been any change to your general health within the last year?** YES NO

2. **Are you now under the care of a physician?** YES NO
   If so, what is the condition being treated?

   _____

3. **Have you had any serious illness or operation?** YES NO
   If so, what was the illness or operation?

   _____

Any artificial heart valves, hip joints, etc.? / When? YES NO

Cardiac pacemaker? YES NO

Have you ever been told you routinely need antibiotics before dental treatment? YES NO

4. **Do you have or have you ever been told you have any of the following diseases or conditions?**

Rheumatic fever, heart murmur	YES	NO
Cardiovascular disease (heart trouble, heart attack, arrhythmia, prolapsed valve, high blood pressure, arteriosclerosis, stroke)	YES	NO
Allergy	YES	NO
Asthma	YES	NO
Hay Fever	YES	NO
Hives or Skin Rash	YES	NO
Fainting Spells or Seizures	YES	NO
Kidney Trouble	YES	NO
Diabetes	YES	NO
Arthritis	YES	NO
Stomach Ulcers	YES	NO
Tuberculosis	YES	NO
Hepatitis, Jaundice or Liver Disease	YES	NO
Venereal Disease	YES	NO
AIDS and/or HIV	YES	NO
Autoimmune Disorder	YES	NO
Chronic Cough, Cough Up Blood	YES	NO
Night Sweats	YES	NO
Other _____	YES	NO

5. **Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?** YES NO

   Do you bruise easily? YES NO

   Have you ever required a blood transfusion? YES NO

   Is so, explain the circumstances _____

   _____

6. **Do you have any blood disorder such as anemia?** YES NO

7. **Are you taking any of the following drugs or medicines?**

Cortisone (Steroids)	YES	NO
Tranquilizers, Sedatives or Anti-Depressants	YES	NO
Antibiotics	YES	NO
Aspirin, Tylenol, Ibuprofen	YES	NO
Insulin, Tolbutamide (Orinase) or Similar Drug	YES	NO
Anticoagulants (Blood Thinners)	YES	NO
Digitalis or Drug for Heart Trouble	YES	NO
Nitroglycerin	YES	NO
Medicine for High Blood Pressure	YES	NO
Oral Contraceptives (Birth Control Pills)	YES	NO
Biophosphonates (Osteoporosis Meds.)	YES	NO
List medicines you are currently taking or have taken in the last year: _____	YES	NO

8. **Are you allergic or have you reacted adversely to:**

Penicillin, other antibiotics, please list: _____	YES	NO
Sulfa Drugs	YES	NO
Barbiturates, Sedatives, or Sleeping Pills	YES	NO
Aspirin, Tylenol, Ibuprofen	YES	NO
Iodine/Seafood	YES	NO
Codeine	YES	NO
Bisulfites (Salad Bars), Red Wine?	YES	NO
Latex or Latex Products/Bandaids	YES	NO
Other _____	YES	NO

9. **Do you have any disease, condition, or problem not listed above that you think I should know about?** YES NO
   If so, please explain _____

   _____

Are you pregnant or nursing? (Women) YES NO

X: _____ X: _____

Patient Signature Date Date

X: _____ X: _____

Person Responsible For Account Date Patient/Guardian Signature Date

PERMISSION TO DIAGNOSE AND TREAT MINOR PATIENT