PRESTIGE ENDODONTICS

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american association of endodontists

AMERICAN BOARD OF ENDODONTICS

PATIENT REGISTRATION AND HISTORY

PATIENT INFORMATION

Name: _____ Phone: _____
Last Name First Name Middle

Home Address: _____
Street Apt. City State Zip

Sex: ____ M ____ F Age: _____ Birthday: _____/_____/_____ SS#/ID#: _____

Patient Employed By: _____ DL#: _____

Business Address: _____ Occupation: _____

_____ Business Phone: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____ Phone: _____

DENTAL INSURANCE

Primary Insurance:

Name of Insurance Company: _____ Phone: _____

Member Name: _____ Relation to Patient: _____

Member Date of Birth: _____ Member SS#/ID#: _____

Member's Employer: _____ Group # (Plan or Policy #): _____

Employer's Address: _____ Phone: _____
Street City Zip

Secondary Insurance: (If Applicable)

Name of Insurance Company: _____ Phone: _____

Member Name: _____ Relation to Patient: _____

Member Date of Birth: _____ Member SS#/ID#: _____

Member's Employer: _____ Group # (Plan or Policy #): _____

Employer's Address: _____ Phone: _____
Street City Zip

DENTAL HISTORY

Reason for today's visit: _____

Are you currently in pain? YES NO

Are your teeth sensitive to (circle)

COLD HOT BITE Anything else? _____

How often do you floss and brush? _____

Do your gums ever bleed? YES NO

Have you ever had periodontal disease? YES NO

Present family dentist: _____ Phone: _____

All information will remain secure and confidential.

Turn Over, continued on Back →

MEDICAL HISTORY

Physician's Name: _____ Phone: _____ Date of last visit: _____

AIDS	YES	NO	Fainting or dizziness	YES	NO	Psychiatric Care	YES	NO
Anemia	YES	NO	Glaucoma	YES	NO	Radiation Treatment	YES	NO
Arthritis	YES	NO	Headaches	YES	NO	Respiratory Disease	YES	NO
Artificial Heart Valves	YES	NO	Heart Murmur	YES	NO	Rheumatic Fever	YES	NO
Artificial Joints	YES	NO	Heart Problem	YES	NO	Scarlet Fever	YES	NO
Asthma	YES	NO	Hepatitis	YES	NO	Shortness of Breath	YES	NO
Back Problem	YES	NO	Type _____			Sinus Trouble	YES	NO
Bisphosphonate (Fosamax) treatment	YES	NO	Herpes	YES	NO	Skin Rash	YES	NO
Bleeding abnormally with extraction	YES	NO	High Blood Pressure	YES	NO	Special Diet	YES	NO
Blood Disease	YES	NO	History of Phen-Fen	YES	NO	Stroke	YES	NO
Cancer	YES	NO	HIV Positive	YES	NO	Swelling of Feet or Ankles	YES	NO
Chemical dependency	YES	NO	Jaundice	YES	NO	Swollen Neck Glands	YES	NO
Chemotherapy	YES	NO	Jaw Pain	YES	NO	Thyroid Problem	YES	NO
Circulatory	YES	NO	Kidney Disease	YES	NO	Tonsillitis	YES	NO
Cortisone Treatment	YES	NO	Liver Disease	YES	NO	Tuberculosis	YES	NO
Diabetes	YES	NO	Low Blood Pressure	YES	NO	Ulcer	YES	NO
Emphysema	YES	NO	Mitral Valve Prolapse	YES	NO	Venereal Disease	YES	NO
Epilepsy	YES	NO	Pacemaker	YES	NO	Drug Addiction	YES	NO
			Surgery	YES	NO	Alcohol Abuse	YES	NO
			Smoking	YES	NO			

WOMEN ONLY:

Are you pregnant? YES NO Due Date: _____ Are you nursing? YES NO

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name: _____

Phone Number: _____

ALLERGIES (circle)

Aspirin
Barbituates (Sleeping Pills)
Codeine
Iodine
Latex
Local Anesthetic
Penicillin
Sulfa Drug
Other _____

ASSIGNMENT AND RELEASE

This is my consent to the examination and dental treatment performed at this office. I hereby authorize the doctor to release all information necessary to secure the payment of benefits directly to my doctor. I understand and acknowledge that I am financially responsible for all charges for myself or the above named, regardless of insurance coverage. If my insurance company has not paid the clinic within 45 days, I will be responsible for the whole (uncollected) treatment fee. I also authorize the use of this signature on all insurance submissions.

Patient: _____ Date: _____ Witness: _____
(Signature)

Parent or Responsible Party: _____ Relation to Patient: _____
(Signature)

Reviewed by: Dr. _____ Date: _____

MEDICAL HISTORY UPDATE:

1. Date: _____ Signature: _____
   Comments: _____
2. Date: _____ Signature: _____
   Comments: _____