PATIENT REGISTRATION AND MEDICAL HISTORY FORM

Patient's Full Name: _____ circle⇨ Male Female

Mailing Address: _____ City: _____ State: _____ Zip: _____

Marital Status: circle⇨ M S W D Birth Date: _____ SSN _____

Home Phone #: _____Spouse's Name: _____ SSN _____

Spouse's Birth Date: _____

Person responsible of account: circle⇨ Self Spouse Parent* Other*

*If parent or Other, please list name, address, employer, phone #, S.S.#, birth date and insurance on the back of this sheet.

Your Employer: Name: _____ Address: _____

Phone: _____ Position: _____

Spouse's Employer: Name: _____ Address: _____

Phone: _____ Position: _____

Where may we leave a message: circle⇨ Home Work Other_____

Primary Dental Insurance Company:_____

Carrier (Family Member) _____ Group # _____Agreement # _____

Referring Dentist: _____How long have you been his/her patient?___

Is this Appointment for: circle⇨ Consultation Treatment Both

Have you or any family member been a patient here? circle⇨ No Yes When Who_____

Are you in pain? circle⇨ No Yes

Has your dentist prescribed any medication? circle⇨ No Yes List

Have you previously had a root canal? circle⇨ No Yes When_____

In case of emergency contact _____ *Phone* _____

PERMISSION FOR X-RAYS, CONSULTATION AND/OR ROOT CANAL PROCEDURES

To the best of my knowledge, all answers on this form are correct. I will notify the doctor of any changes in my health or medications.

I, the undersigned, consent to the dental procedures decided upon to be necessary or advisable in the opinion of the doctor, of which I am informed and to which I agree.

I also understand that only the root canal treatment is to be completed at this office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be performed by my general dentist.

How will you be paying for your treatment today?

circle⇨ Visa Mastercard Am. Exp. Discover Check # _____ Cash

SIGNATURE:_____ Date: _____