LAS VEGAS ENDODONTICS

Patient Registration

PATIENT INFORMATION

First Name		MI		Last Name			
Preferred Name		Sex	❑ Male ❑ Female ❑ Other		Birth Date		
Social Security #		E-mail					
Address		City		State		ZIP Code	
Home Phone		Cell Phone		Work Phone			
Marital Status	❑ Single ❑ Married ❑ Separated ❑ Widowed ❑ Divorced ❑ Other						
Employer Name		Occupation					

Whom may we thank for referring you to our practice?

Referral Name	

RESPONSIBLE PARTY (if self is selected, please skip to the next section)

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other: _____

First Name		MI		Last Name		Birth Date	
Preferred Name		Sex	❑ Male ❑ Female ❑ Other		Driver's License #		
Social Security #		E-mail					
Address		City		State		ZIP Code	
Home Phone		Cell Phone		Work Phone			

EMERGENCY CONTACT

First Name		Last Name	
Telephone		Relationship to Patient	

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY

Insurance Co. Name			Insurance Co. Phone		
Subscriber Name				Birth Date	
Relationship to Patient		Social Security #		Member ID #	
Home Phone		Cell Phone		Work Phone	
Subscriber Employer			Group #		

Do you have secondary dental insurance?	❑ Yes ❑ No

SECONDARY DENTAL INSURANCE COMPANY

Insurance Co. Name			Insurance Co. Phone		
Subscriber Name				Birth Date	
Relationship to Patient		Social Security #		Member ID #	
Home Phone		Cell Phone		Work Phone	
Subscriber Employer			Group #		

HEALTH HISTORY

Physician's Name		City		Phone	
Are you under a physician's care now or during the last 2 years?					❑ Yes ❑ No
Preferred Pharmacy		Location		Phone	
Have you ever had an injury to the head, mouth or teeth?					❑ Yes ❑ No
If yes, please explain					

Have you ever been advised to take an antibiotic prior to a dental procedure due to a heart problem or artificial joint?	❑ Yes ❑ No
If yes, please explain	

Have you recently had any of the following symptoms?

❑ Bloody Sputum ❑ Hoarseness ❑ Fatigue ❑ Night Sweats
❑ Chest Pain ❑ Loss of Appetite ❑ Unexplained Weight Loss

Do you have, or have had, any of the following conditions?

	Yes	No		Yes	No		Yes	No
Heart Disease, Surgery or Attack			**Epilepsy or Seizures**			**Asthma**		
High Blood Pressure			**Fainting or Dizzy Spells**			**Hepatitis, Jaundice, Liver Disease**		
Angina Pectoris			**Kidney Disease**			**AIDS or HIV Positive**		
Congenital Heart Lesions			**Diabetes**			**Sexually Transmitted Disease**		
Artificial Heart Valve			**Ulcer or Stomach Trouble**			**Drug or Alcohol Addiction**		
Heart Pacemaker			**Thyroid Disease**			**Cold Sores**		
Artificial Joint			**Tuberculosis (TB)**			**Herpes**		
Hemophilia or Excess Bleeding			**Breast Cancer**			**Arthritis**		
Stroke			**Multiple Myeloma**			**Osteoporosis**		
Glaucoma			**Other Cancer or Tumors**			**Pain in Jaw Joint (TMJ)**		
Psychiatric Treatment			**Chemo or Radiation Therapy**			**Allergies**		
Mental Disorder			**Lung Disease**			**Sinus Trouble**		

Is there any disease, condition, or problem that you think our office should know about that is not listed above?	❑ Yes ❑ No

Please explain/clarify any conditions selected above along with any other condition not listed.

MEDICATIONS

Have you ever taken any of the following medications for Osteoporosis or Cancer Therapy?	❑ Yes ❑ No

❑ Fosamax ❑ Aredia ❑ Boniva ❑ Zometa ❑ Actonel

Please list all medications, over the counter and herbal supplements, that you are currently taking (include medication name, dosage and frequency):

ALLERGIES

Are you allergic to, or had an unusual reaction to any of the following?

	Yes	No		Yes	No		Yes	No
Dental Local Anesthetics			**Latex**			**Penicillin or other Antibiotics**		
Aspirin or Tylenol Compounds			**Anti-inflammatory Drugs**			**Codeine or other Narcotics**		
Motrin, Advil, Aleve, etc.			**Barbiturate or Tranquilizers**			**Other**		

Please list any allergy/reaction not listed.

Women

Are you pregnant?	❑ Yes ❑ No	**If yes, how many months?**		**Are you taking birth control pills?**	❑ Yes ❑ No

WARNING: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control.

FORM COMPLETION

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the dentist of any changes in my health or medication.

Signature of Patient, Parent or Guardian:		**Date:**	

IF PATIENT IS A MINOR

Form signed by:		**Relationship to Patient:**	