superstition springs endodontics, LLP

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PATIENT REGISTRATION

Date: _____ Date of Birth: _____

Patient Name _____ ____ _____ SS #: _____
First Name M.I. Last Name

☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address Street: _____

City: _____ State: _____ Zip: _____

Phone Numbers Home: ( ) _____ Business: ( ) _____

Mobile: ( ) _____ Email: _____

Employer _____

If patient is a minor, who is legally responsible? _____

SS# _____ DOB _____

In case of emergency, who should we contact? _____

Phone: ( ) _____ Relationship: _____

Referred by: _____

Method of Payment: ☐ Cash ☐ Check ☐ Visa or Mastercard

INSURANCE INFORMATION

Is treatment covered by insurance? ☐ Yes ☐ No

Name of Insurance Company _____ Phone:( ) _____

Insurance Address: _____

Subscriber's Name: _____ SS#: _____

Date of Birth: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Group or Policy Number: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Name of Secondary Insurance Company _____ Phone: ( ) _____

Insurance Address: _____

Subscriber's Name: _____ SS#: _____

Date of Birth:: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Group or Policy Number: _____

I hereby authorize payment of the dental and insurance benefits directly to Superstition Springs Endodontics, LLP and authorize them to release dental information to my insurance company in order for claims to be processed. I have received the financial agreement for insurance.

_____
Patient or Guardian Signature

HEALTH HISTORY

PATIENT NAME _____ DATE _____

1. Are you experiencing pain from your mouth at this time? _____ If so, where? _____
2. Have you noticed any loose teeth? _____
3. Are your teeth sensitive to hot, cold or sweets? _____ Which ones? _____
4. On a scale of 0-10, how important are your teeth to you? _____
5. Do you consider your general health to be Good? _____ Fair? _____ Poor? _____
6. When was your last physical evaluation? _____ Findings? _____
7. Has your health changed within the last year? _____ Explain: _____
8. Are you being treated by your physician at this time? _____ If so, why? _____
   Name of physician: _____ Phone: ( ) _____
9. Have you taken bisphosphonates? _____
10. Are you taking any medications, drugs, pills regularly? _____ if so, please list below: _____

    _____ _____ _____ _____ _____

    _____ _____ _____ _____ _____

11. Have you ever had, or do you now have, any of the following?

☐ AIDS/HIV	☐ Blood Disease	☐ Glaucoma	☐ Liver Problems	☐ Rheumatism
☐ Anemia	☐ Bowel Disease	☐ Heart Attack	☐ Low Blood Pressure	☐ Sinus Problems
☐ Angina	☐ Chemotherapy	☐ Heart Disease	☐ Lung Problems	☐ Skin Disease
☐ Arthritis	☐ Clotting Problems	☐ Heart Murmur	☐ Malignancy/Cancer	☐ Stomach Problems
☐ Artificial Heart Valve	☐ Cold Sores	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Hip, Knee	☐ Congestive Heart Failure	☐ Herpes I or II	☐ Pacemaker	☐ Thyroid Disease
☐ Asthma	☐ Diabetes	☐ High Blood Pressure	☐ Psychiatric Treatment	☐ Tuberculosis
☐ Bladder Problems	☐ Emphysema	☐ Jaundice	☐ Radiation Therapy	☐ Ulcer(s)
☐ Bleeding Problems	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever	☐ Venereal Disease

    Women: Are you pregnant? _____ Which month? _____
    Oral contraceptives? _____ Are you taking hormones? _____
12. Have you taken Cortisone/Steroids within the last 2 months? _____
13. Have you taken anti-coagulants (bloodthinner)? _____ When and for how long? _____
14. Note, the drug(s) you have had an allergic reaction or reacted adversely to:

☐ Advil	☐ Aspirin	☐ Darvon	☐ Local Anesthetics	☐ Tetracycline
☐ Antibiotics	☐ Barbiturates	☐ Demerol	☐ Novocaine	☐ Tylenol
☐ Antihistamines	☐ Codeine	☐ Halcion	☐ Penicillin	☐ Valium

    Other _____
15. Have you had major surgery within the last 2 years? _____ Explain? _____

    _____
16. Please describe any current medical treatment, impending operations, or other medical or dental information that may possibly affect your endodontic care: _____

Print Form **Submit Form**

To the best of my knowledge all of the preceding answers are true and correct. If I have any changes in my health, or if my medications change, I will inform my dentist at the next appointment without fail. I further agree to pay all finance charges, collection cost 50%, attorneys fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

_____ _____

Date Signature of Patient or Guardian