REGISTRATION FORM

PATIENT INFORMATION (CONFIDENTIAL) Date: ______/______/_________

Home Phone (_____)______-_________ Cell Phone: (_____)______-_________ Work Phone: (____)______-_________

Name: ______________________________________ Birthdate: _____/_____/_______ Soc. Sec #: _____-_____-_______

Address: ______________________________________ City: _____________________ State: _______ Zip: ___________

E-mail: ____

Best Way to Reach You (Check One): O Home O Work O Cell O E-mail O Text Message

Emergency Contact: _______________________________ Phone: (____)_____-_______ Relationship: _______________

Employer: ____ Occupation: __________________________________

Employer Address: _____________________________________ City: ___________________ State: _____ Zip: ________

Please Check One: O Minor O Single O Married O Divorced O Widowed

(If Applicable) Spouse's Name: ______________________________ Spouse's Phone Number: (_____)______-_________

Spouse's Employer: ____ Business Phone: (_____)_____-_________

RESPONSIBLE PARTY FOR ACCOUNT (Please Skip if Same as Patient)

Name: ______________________________________ Relationship to Patient: ____________________________________

Address: ____ City: ___________________ State: _______ Zip: ___________

Birthdate: ____/____/______ Phone Number: (____)_____-_______ Please Check One: O CELL O HOME O WORK

DENTAL INSURANCE INFORMATION (IF APPLICABLE)

Name of Insured: _________________________________ Relationship to Patient: ______________ DOB: ___/___/_____

Employer Name: ________________________________ Subscriber Soc Sec/ID #: _______________________________

Dental Insurance Company: ___________________________________ Group #: __________________________________

SECONDARY DENTAL INSURANCE (IF APPLICABLE)

Name of Insured: _________________________________ Relationship to Patient: ______________ DOB: ___/___/_____

Employer Name: ________________________________ Subscriber Soc Sec/ID #: _______________________________

Dental Insurance Company: ___________________________________ Group #: __________________________________

DOCTOR INFORMATION

General Dentist: ____ Phone: (_____)______-_____________

Physician: ______________________________ Office Phone: ______________________ Last Visit: ____/____/________

MEDICAL HISTORY

Yes	No		Yes	No		Yes	No	
O	O	High Blood Pressure	O	O	Heart Disease	O	O	Stroke - Date:_______________
O	O	Hay Fever/Allergies	O	O	Cardiac Pacemaker	O	O	Heart Attack - Date:__________
O	O	Rheumatic Fever	O	O	Heart Murmur (MVP)	O	O	Angina (Chest Pain) Often: ____
O	O	Thyroid Problem	O	O	Liver Disease	O	O	Seizures - Date: _____________
O	O	Emphysema	O	O	Osteoporosis	O	O	Radiation Therapy - Date: _____
O	O	Sinus or Nasal Problems	O	O	Anemia	O	O	Cancer - Date: ______________
O	O	Asthma	O	O	Glaucoma	O	O	Chemotherapy - Date: ________
O	O	Low Blood Pressure	O	O	Recent Weight Loss	O	O	Arthritis - Type: _____________
O	O	Epilepsy/Convulsions	O	O	Fainting	O	O	Diabetes Type I or II A1C: ____
O	O	Leukemia	O	O	AIDS or HIV Infection	O	O	Sexually Transmitted Disease
O	O	Psychiatric Treatment	O	O	Hepatitis/Jaundice	O	O	Joint Replacement Date: ______
O	O	Kidney Disease	O	O	Tuberculosis	O	O	Other: ____________________
O	O	Bleeding Disorder	O	O	Stomach Ulcers			_________________________

1. Have you ever been hospitalized for any surgical operation or serious illness? O YES O NO

2. Do you need to be premedicated? O YES O NO

3. Are you taking any medication(s) including non-prescription medicine? (Aspirin, Vitamins, etc) O YES O NO
   If yes, what medication(s) are you taking? ____
____

4. Do you have any allergies? (Medications, Latex, etc) O YES O NO
   If yes, what are you allergic to? ____

5. Do you smoke? O YES O NO O CIGARETTES O PIPE O CIGARS How many per day? _______/day

6. Women Only
   a. Are you pregnant or think you may be pregnant? O YES O NO
   b. Are you nursing? O YES O NO
   c. Are you taking birth control pills? O YES O NO

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrection information can be dangerous to my health. I authorize Southwest Endodontics & Periodontics, Inc to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I agree to pay any service charges on the account or balance due, together with any returned check fees, collections agency costs, and reasonable attorney fees incurred to effect collection on this account. I understand that my dental insurance carrier may pay less than the dental bill for services. I certify that I can read and write English and I agree to be responsible for payment of all services rendered on my behalf or my dependent.

____ _________________________________
Signature of Patient or Parent if Minor Date

COMMENTS: ____
____
____

____
Signature of Doctor Date