ENDODONTIC
ASSOCIATES,LLC

PATIENT REGISTRATION FORM

ENDODONTIC ASSOCIATES, LLC

HAVE YOU OR ANY OTHER MEMBERS OF YOUR FAMILY VISITED US BEFORE? ☐ YES ☐ NO

PLEASE PRINT

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	LAST NAME	FIRST	INITIAL

BIRTH DATE (MONTH/DAY/YEAR)	AGE: WEIGHT:	☐ MALE	☐ FEMALE

HOME ADDRESS	NO. & STREET	APT.	
	CITY	STATE	ZIPCODE

BILLING ADDRESS (ONLY IF DIFFERENT FROM HOME ADDRESS)	NO. & STREET	APT.	
	CITY	STATE	ZIPCODE

HOME PHONE	CELL PHONE	STATE ID OR DRIVER'S LICENSE #	EMAIL
EMPLOYER		BUSINESS PHONE	OCCUPATION

IF YOU ARE A DEPENDENT WHO WILL BE FINANCIALLY RESPONSIBLE?	WHAT IS THEIR RELATION?

INDICATE ANY DENTAL INSURANCE ☐ NONE ☐ HDS ☐ HMSA ☐ MEDICAID ☐ OTHER (please indicate)

SPOUSE'S NAME	SPOUSE'S BUSINESS PHONE
SPOUSE 'S EMPLOYER	SPOUSE'S OCCUPATION
WHO IS YOUR REGULAR DENTIST	FOR HOW LONG?
REFERRED BY:	FAMILY PHYSICIAN

EMERGENCY CONTACT: NAME	PHONE NO.	RELATIONSHIP TO PATIENT

DO YOU HAVE ANY HISTORY OF THE FOLLOWING? ☐ NO ☐ YES (IF YES, CHECK THE APPROPRIATE BOXES)

☐ Arthritis	☐ Heart Murmur	☐ Osteoporosis
☐ Asthma	☐ Heart Trouble	☐ Pacemaker
☐ Artificial Heart Valve	☐ Hepatitis	☐ Rheumatic Heart Disease
☐ Blood Disease	☐ High Blood Pressure	☐ Sinus Trouble
☐ Cancer	☐ HIV+	☐ Stroke
☐ Chemotherapy w/ Aredia or Zometa	☐ Joint Replacement	☐ Tuberculosis
☐ Diabetes	☐ Kidney Trouble	☐ Other
☐ Epilepsy	☐ Mitral Valve Prolapse	

Do you need to take antibiotics (premed) **before** any dental work? ☐ YES ☐ NO

Do you take daily aspirin or blood thinners? (circle one) ☐ YES ☐ NO

Have you had chemotherapy w/ Aredia or Zometa ☐ YES ☐ NO

Are you sensitive or allergic to any medication or anesthetic? ☐ YES ☐ NO

IF YES which one? _____

_____

WOMEN: Are you pregnant? ☐ YES due date _____ ☐ NO

Are you taking birth control? ☐ YES ☐ NO

Note: antibiotics may alter the effectiveness of birth control, please consult your physician/ gynecologist for assistance regarding additional methods of birth control

List any MEDICATIONS you are taking. ☐ NONE

_____

_____

_____

_____

_____

Are you taking Bisphosphonates (like, but not limited to Actonel, Boniva, Fosamax)? ☐ YES ☐ NO

Signature _____
Patient / parent if minor

Date _____