



ABILENE ENDODONTICS ROOT CANAL SPECIALISTS

CONTACT INFORMATION:
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REGISTRATION FORM

(Please Print)

Today's date:

Referring Dentist:

PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()	
P.O. box:	City:		State:	ZIP Code:		
Occupation:		Employer:		Employer phone no.: ()		

Other family members seen here:

DENTAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: ()	
Occupation:	Employer:	Employer address:			Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Primary Insurance:				
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):				Subscriber's name:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	Group no: Policy no:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _____

Date _____

PATIENT NAME: _____

DATE: _____

PLEASE CHECK YES OR NO TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS OR TREATMENTS:

Actonel	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes Type I	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes Type II	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies (Seasonal)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you Pregnant or Nursing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fosamax	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you using oral contraceptives	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bisphosphonate	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Boniva	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hormone Replacement Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemo-Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Cortisone/Steroid Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		

ARE YOU ALLERGIC OR HAVE REACTED ADVERSELY TO:

- Nova Caine Codeine Penicillin Aspirin Adhesives or Tape
 Latex Iodine Barbiturates Sulfa Drugs Other _____

DO YOU TAKE ANTIBIOTIC THERAPY FOR A MEDICAL CONDITION BEFORE DENTAL WORK? _____

Did or Do you smoke Yes No How many Packs/day _____ How many years _____ Quit Date: ___/___/___

LIST MEDICATION AND HERBAL REMEDIES YOU ARE TAKING ON A REGULAR BASIS:

List Hospitalizations, Serious Illness and Surgeries for the past 5 years (list date and procedure):

Physicians _____ Physician's Phone # _____

Pharmacy Name _____ Pharmacy Phone # _____

Consent for Assignment of Benefits and treatment: I certify that me or my dependents have insurance coverage with the above names carrier and I assign directly to Abilene Endodontics, PC all insurance benefits, if any, otherwise payable to me, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above names practice, its agents, and assignees may use my health care information and may disclose such information to above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I grant permission for the above names endodontist, or endodontic associates and their assistants to render care in the diagnosis and/ or treatment of my dental conditions and release related information to my 3rd party payers, physician and/or emergency medical personal and as required by law.

 Signature of Patient, Parent, Legal Guardian or Personal Representative

 Printed Name of Patient, Parent, Legal Guardian or Personal Representative

Reviewed by Dr. _____ Date: _____ Assistant: _____