

Patient Registration

(Please Print)

Married _____
 Single _____
 Widowed _____
 Divorced _____

_____ Last Name _____ First Name _____ Middle Initial _____

Address _____ Date of Birth _____
 Street City State Zip

Social Security # _____ If patient is a minor, responsible parent _____ Home Phone _____
 Business Phone _____ Employed by _____ Occupation _____
 General Dentist _____ Referred by _____
 Physician _____ Phone _____ Date of Last Physical _____
 In case of emergency contact _____ Relationship _____ Phone _____

Health History

Are you under the care of a physician? Yes No For what condition? _____
 In the last five years, have you ever been: (If yes, please circle and explain) _____
 Hospitalized: Yes No _____
 Had a serious illness? Yes No _____
 Do you have a prosthetic joint? Yes No If so, describe where: _____
 Do you have a heart valve replacement of vascular graft? Yes No Where? _____
 Must you take an antibiotic before dental treatment? Yes No If so, what and how many? _____

Have you had or do you currently have...	Yes	No	Notes	Have you had or do you currently have...	Yes	No	Notes
Heart murmur				Kidney disease			
Mitral valve prolapse				Tuberculosis			
Rheumatic fever				Asthma			
High blood pressure				Anemia			
Chest pain, angina				Hepatitis/liver disease			
Heart attack				Arthritis			
Stroke				Ulcers			
Cardiac pacemaker				HIV/AIDS			
Heart surgery				Seizures			
Thyroid trouble				Glaucoma			
Diabetes				Sinusitis			
Cancer				TMJ pain or "clicking"			

Medications: _____

Allergies

Are you allergic to or have you had a reaction to:	Yes	No	Notes	Are you allergic to or have you had a reaction to:	Yes	No	Notes
Local anesthetics (Adrenalin)				Codeine or other narcotics			
Penicillin				Other medications			
Other antibiotics				Other non-drug allergies			
Aspirin or Ibuprofen				Latex			

Women: Are you pregnant? Yes No If so, estimated delivery date: _____ Are you nursing? _____

Chief Dental Complaint _____

Have you ever had a root canal before? Yes No

(over)

Patients with Insurance

Is treatment covered by insurance? Yes No

Name of Insurance Company _____ Phone _____

Insurance address _____ City _____ State _____ Zip _____

Subscriber's Name _____ SS# _____

Birth Date _____ Patients Relationship to Subscriber _____

Subscriber's Address _____

Subscriber's Employer _____ Group or Policy # _____

Is patient covered by additional insurance? Yes _____ No _____ If "Yes" please complete information

Name of secondary insurance company _____ Phone _____

Insurance address _____

Subscriber's Name _____ SS# _____

Birth Date _____ Patient's relationship to Subscriber _____

Subscriber's Employer _____ Group or Policy # _____

I understand that my dental benefits are based upon a contract between my insurance carrier and myself. I assign all of my insurance benefits to Lehigh Valley Endodontics, LLC. Should that amount be insufficient to cover my dental fees, then I understand that I am fully responsible for the difference. In addition, I am responsible for any other fees including those incurred for delinquency and/or insufficiency. Any payments received by Lehigh Valley Endodontics from my insurance carrier and/or myself shall be credited to my account or refunded to me if in excess of the amount due.

Patient / (or Guardian) Signature

Date

Patients without Insurance

I understand that I am fully responsible for all dental fees and that these fees are due and payable at the time services are rendered, unless a prior financial arrangement has been made. I further understand that I am responsible for those fees incurred for delinquency and/or any other insufficiency (e.g.-those incurred by a collection agency or an attorney).

Patient / (or Guardian) Signature

Date

All Patients

I, the undersigned, certify that the information on these pages is correct and accurate. I also certify that I am the patient (or authorized agent of the patient) authorized to furnish all information requested.

Patient / (or Guardian) Signature

Date

Return Visit Update

(For patients who have not been seen at our office in one year or longer)

Date _____

Have there been any changes in your medical history since the last time you were in our office? Yes No

Comments _____

Signature