# PATIENT REGISTRATION AND MEDICAL HISTORY

Phone:Home _____Work_____Cell_____(Best Number to Call)_____

E-Mail_____

Patient_____
Last name First name Middle Initial Nick Name

Mailing Address_____City_____State_____Zip Code_____

Sex: ☐M ☐F Age_____ Birthdate_____ Social Security #_____ The reason we ask for your social security number is so we may verify and file your dental insurance. Without it we are unable to provide this service. If you do not wish to provide us with your social security number then you will have to pay your fee in full at the time of service and file your own dental insurance.

Employer_____Occupation_____

Who may we thank for referring you?_____

In case of emergency, who should be notified?_____Phone_____

Have you ever had any of the following? (**CHECK BOXES THAT APPLY**)

| | | |
|---|---|---|
| ☐Heart Murmur | ☐Stroke | ☐Sinus trouble |
| ☐Diabetes | ☐Tuberculosis | ☐Asthma |
| ☐Cancer | ☐Thyroid Problems | ☐Fainting spells |
| ☐Seizures | ☐A.I.D.S./H.I.V. | ☐High blood pressure |
| ☐Arthritis | ☐Pacemaker | ☐Low blood pressure |
| ☐General Allergies | ☐Hepatitis | ☐Artificial knee, hip or joint |
| ☐Artificial Heart Valves | ☐Mitral valve Prolapse | ☐Epilepsy |
| ☐Swollen neck glands | ☐Rheumatic Fever | ☐Anxiety or panic attacks |
| ☐Sexually transmitted disease | ☐Immune Problems | ☐Kidney trouble |
| ☐Ulcers | ☐Cardiovascular disease | ☐Respiratory problems |
| ☐Psychiatric Care | ☐Chemical Dependency | ☐Anemia |

☐other_____

Are you allergic or have you had a reaction to:

| | | |
|---|---|---|
| ☐Local anesthetics | ☐Penicillin | ☐Other _____ |
| ☐Aspirin | ☐Codeine | |
| ☐Iodine | ☐Sulfa | |

If you are taking any medicine including non-prescription medicine, please list.
_____

_____
The following question is for patients with heart murmurs, rheumatic heart disease, joint replacements, artificial plastic surgery or other known reasons that an antibiotic is needed before dental treatment and that you have been advised by your treating physician that you should be pre-medicated. **Are you pre-medicated?** ☐yes ☐no

**(Women)**
Are you pregnant? ☐ yes ☐ no Are you nursing? ☐ yes ☐ no Are you taking birth control pills? ☐ yes ☐ no

This above information is accurate and complete to the best of my knowledge and is only for use in my treatment. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Date_____ Signature_____

# DENTAL INSURANCE INFORMATION

**ASSIGNMENT AND RELEASE** ***(For patients with Dental Insurance)***

I, the undersigned, have insurance with _____ and assign benefits
**Name of insurance company**
directly to Advanced Endodontics. I understand that my co-payment is an **ESTIMATE** based on the information provided by my insurance carrier. THIS IS NOT A GUARANTEE OF PAYMENT BY MY INSURANCE CARRIER. My carrier will process my claim based on the provisions of my policy and the current information from my employer. **FILING INSURANCE CLAIMS IS A SERVICE PROVIDED WITHOUT CHARGE AND IN NO WAY RELIEVES ME OF RESPONSIBILITY FOR MY BILL. I AM AWARE THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY CARRIER.**

_____ _____ _____

**Date** **Signature of Insured** **Consent For Minor**

**MINOR/CHILD CONSENT**

I being the parent or guardian of_____ do hereby request and authorize the dental staff to perform necessary dental services for my child including but not limited to X-rays and administration of anesthetics which are deemed advisable by the doctor whether or not I am present at the actual appointment when the treatment is rendered. I agree that parents/guardian is responsible for all fees and services rendered for treatment of a minor/child.

**FINANCIAL STATEMENT (*All patients must sign)***

I acknowledge that payment is due at the time of treatment. I accept full financial responsibility for all charges.

_____ _____

**Date** **Signature of insured/guardian**

## PATIENT ACKNOWLEDGEMENTS

- ☐ I affirm that the information contained in this form and any additional information that I may furnish is true and correct to the best of my knowledge. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I will not hold Dr. Goodis or the staff responsible for any errors or omissions that I have made in the completion of this form.
- ☐ I hereby acknowledge that I have been given the right to review this office's Notice of Privacy Practices. (HIPAA) A copy of this notice can be copied if you would like one.

**Signature_____Date_____**