SOUTHEAST ENDODONTICS, PC

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Patient Registration

Dr.
Mr.
Mrs.
Ms._____Date of Birth____/____/_____
First MI Last

Street Address_____

City_____ State_____ Zip Code_____

Home Phone ( )_____ Business Phone ( )_____

SS#_____–_____–_____Occupation_____

If patient is a minor, who is legally responsible?_____

In case of emergency, who should we contact? _____

Phone ( )_____ Relationship_____

Referring Dentist _____

Insurance Information

Do you have dental insurance? ❑ Yes ❑ No
Name of Insurance Company _____
Insurance Address _____
Subscriber's Name _____ ID# _____
Subscriber's Date of Birth _____/_____/_____
Patient's Relationship to Subscriber _____
Subscriber's Employer _____ Group or Policy # _____

Do you have additional dental insurance? ❑ Yes ❑ No
Name of Insurance Company _____
Insurance Address _____
Subscriber's Name _____ ID# _____
Subscriber's Date of Birth _____/_____/_____
Patient's Relationship to Subscriber _____
Subscriber's Employer _____ Group or Policy # _____

Medical History

Name of Physician: _____ Phone #: _____
Are you in good health? ❑ Yes ❑ No

In the last five years, have you been: (if yes, please explain)

a. Hospitalized? ❑ No ❑ Yes _____
b. Had a serious illness? ❑ No ❑ Yes _____
c. Had a major operation? ❑ No ❑ Yes _____

Have you ever been told to take antibiotics before dental visits? ❑ Yes ❑ No

Please check any of the following that pertain to you:

❑ Heart Surgery, Disease or Attack
❑ Angina Pectoris/ Chest Pain
❑ High/Low Blood Pressure
❑ Stroke
❑ Rheumatic Fever/Heart Disease
❑ Heart Murmur/MVP
❑ Pacemaker
❑ Hip Replacement
❑ Kidney Disease
❑ Cancer or Tumors
❑ Thyroid Disease
❑ Lung Disease/ Tuberculosis
❑ Diabetes
❑ Jaw Joint (TMJ) Problems
❑ Surgery or X-ray Treatment For a Tumor, Growth
❑ AIDS or HIV positive
❑ Hepatitis, Jaundice or Liver Disease
❑ Blood Transfusion
❑ Drug Addiction/Alcoholism
❑ Hemophilia or excessive bleeding
❑ Sexually transmitted disease
❑ Herpes
❑ Psychiatric Treatment/Mental Disorders
❑ Asthma
❑ Sinus Trouble (Sinusitis)
❑ Seizures/Epilepsy
❑ Arthritis
❑ Other _____

Please list any **medications** (over the counter, herbal, or prescription) that you are taking:

_____
_____
_____
_____

Have you had an **allergic** or unusual reaction to any of the following?

Dental local anesthetics	❑ Yes ❑ No	PENICILLIN	❑ Yes ❑ No
Ibuprofen (Advil)	❑ Yes ❑ No	Other Antibiotics	❑ Yes ❑ No
Acetaminophen (Tylenol)	❑ Yes ❑ No	LATEX	❑ Yes ❑ No
Codeine	❑ Yes ❑ No	Other _____	

Women:

Are you **pregnant**? ❑ Yes ❑ No If yes, how many months? _____ Are you Nursing? ❑ Yes ❑ No
Are you currently taking **Oral Contraceptives***? ❑ Yes ❑ No

***If you are taking oral contraceptives, please read the following:** Antibiotics may inactivate birth control medication. Therefore, if you need to take antibiotics during/after root canal treatment, additional birth control methods should be used until your next menses.

Patient Signature _____ Date:_____/_____/_____