Medford Endodontics

~~~~Confidential Patient Information~~~~

REGISTRATION FORM – Please fill out form completely. Thank you.

Section I: Patient Information Date_____

Name: _____ I prefer to be called: _____

Date of Birth: _____ Social Security Number: _____-_____-_____

Address: _____City:_____State:_____Zip_____

Email Address_____@_____

Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

The best time to contact me is: _____ ☐ A.M. ☐ P.M. On my ☐ Home phone ☐ Work phone ☐ Cell phone

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: _____ Employer: _____

Parent Name (if patient is a minor): _____ Phone # _____

Who is your general dentist? _____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone_____

Section II Responsible Party (If OTHER Than Patient)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____ Relationship to Patient: _____

Address: *(if different from above)* _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Employer_____ Work Phone (____) _____ SSN#_____

Section III Primary DENTAL Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____

Insurance Carrier_____ ID#_____ Grp #_____

Ins Co Address: _____ INS Co. Phone: _____

Name of Employer: _____ Work Phone: (_____) _____

Address of Employer: _____City_____State:_____Zip _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____DOB_____Relationship to Patient _____

Insurance Carrier_____ ID#_____ Grp #_____

Ins Co Address: _____ INS Co. Phone: _____

Name of Employer: _____ Work Phone: (_____) _____

Address of Employer: _____City_____State:_____Zip _____

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Patient Name: _____ Date of Birth: _____

Name of Physician: _____ Phone: _____

Date of last visit: _____ Reason for last visit: _____

Do you take aspirin or any other blood thinning medications daily? ☐YES ☐NO

What medications, vitamins, or supplements are you currently taking? Please list them below:

_____

_____

_____

Have you ever taken a Bisphosphonate medication, such as Boniva, Fosamax, or Actonel? ☐YES ☐NO

Have you ever taken weight-loss medications, such as Phen-Fen, Redux, Fenfluramine, or Pondimin? ☐YES ☐NO

Are you Pregnant? ☐NO ☐YES – I am #_____ weeks. Are you on Birth Control? ☐YES ☐NO

(ANTIBIOTICS MAY INTERFERE WITH THE EFFECTIVENESS OF ORAL CONTRACEPTIVES)

DO YOU PRE-MEDICATE BEFORE DENTAL WORK FOR A HEART CONDITION, ARTIFICIAL JOINTS, OR OTHER REASONS? ☐YES ☐NO

Do you now or have you ever had any of the following diseases or medical conditions?

Alcohol Abuse ☐YES ☐NO	**Diabetes ☐YES ☐NO**	**Drug Abuse ☐YES ☐NO**
Anemia ☐YES ☐NO	**Epilepsy ☐YES ☐NO**	**Seizures ☐YES ☐NO**
Asthma/Breathing Problems/Emphysema ☐YES ☐NO	**Heart Valve Replacement/Other Surgery ☐YES ☐NO (Date) _____**	**Defibrillator/Pacemaker ☐YES ☐NO (Date placed) _____**
Arthritis ☐YES ☐NO	**Congenital Heart Defect ☐YES ☐NO**	**Sinus Problems ☐YES ☐NO**
Bleeding Problems / Hemophilia ☐YES ☐NO	**High Blood Pressure ☐YES ☐NO**	**Steroid Therapy ☐YES ☐NO**
Cancer/Chemotherapy/Radiation ☐YES ☐NO (Date/Type)_____	**Heart Attack/Stroke ☐YES ☐NO (Date) _____**	**Knee/Hip/Other Joint Replacement ☐YES ☐NO (Date)_____**
Colitis ☐YES ☐NO	**Heart Murmur/MVP ☐YES ☐NO**	**Thyroid Treatment ☐YES ☐NO**
Dizzy Spells/Fainting ☐YES ☐NO	**Hepatitis (type?) _____ ☐YES ☐NO**	**Ulcers ☐YES ☐NO**
Tuberculosis ☐YES ☐NO	**Liver or Kidney Disease ☐YES ☐NO**	**HIV/AIDS ☐YES ☐NO**

Do you have TMJD (temporomandibular joint disorder)? ☐YES ☐NO

Do you have any other medical conditions? If so, please list: _____

_____

Have you had any recent hospitalizations? If so, when and for what? _____

_____

Are you allergic to any of the following?

Aspirin ☐YES ☐NO	**Local Anesthesia ☐YES ☐NO**	**Penicillin ☐YES ☐NO**
Codeine ☐YES ☐NO	**Latex ☐YES ☐NO**	**Other Antibiotics ☐YES ☐NO**

Please list any other allergies: _____

_____

_____ _____

Patient Signature **Date** **Reviewed by Doctor / Date**

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Acknowledgement of Receipt of Notice of Privacy Practices

I have seen and understand the HIPAA policy as posted in this office, and have received a copy of the HIPAA Policy if I have requested one.

X

Signature of patient or parent/guardian **Date**

Authorization, Release, and Agreement to Pay for Services Rendered

I authorize Medford Endodontics to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care, to third party payors and/or other health practitioners, such as my own general dentist.

I authorize and hereby request my insurance company to pay directly to Medford Endodontics any and all insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. I understand that if my account ends in default, I will be responsible for any costs incurred during the collection process, as well as my balance.

X

Signature of patient or parent/guardian **Date**

Restoration Required

I understand that only root canal therapy will be performed in this office. A subsequent restoration (filling, onlay, crown, etc.) will be needed, and needs to be done by my general dentist within a few weeks of completing the root canal therapy.

I understand that failure to follow through with the restoration may result in re-infection of the tooth (which will require retreatment of the root canals at an additional cost), fracture, and/or possible loss of the tooth.

If a root canal treatment cannot be completed due to complication, there will be a charge for all procedures performed up to that point. There will be a full charge for all completed cases regardless of the success or failure. No warranty or guaranty of success can be given in root canal treatment.

X

Signature of patient or parent/guardian **Date**
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