PATIENT REGISTRATION

Thank you for choosing our office to assist you with your dental needs.

Please fill out the information below and don't forget to provide you signature below.

Circle one: ***Mr.*** ***Mrs.*** ***Ms.*** ***Dr.***

Patient Name_______________________________________ Date of Birth______________

SS #:___________________If minor, name of legal guardian___________________________

Home/Cell phone________________________________ Work phone________________

Email address:____

Mailing address:____

City_________________________ State ____________________ Zip______________

Emergency Contact:____

Employer____

General Dentist_________________________ Referring Dentist________________________

Insurance Information: ☐ no dental insurance

Insured's SS#___________________________ or Member ID#_________________________

Insurance Company______________________________ Group #______________________

Covered by spouse, significant other or parent's insurance? Yes No

Insured's Name_________________________________ Date of Birth____________________

Relationship to patient____________________________________

Insurance Company__________________________ Group#_________________________

SS# or Member ID#____

***We are not part of any insurance network**. We are not responsible for insurance companies refusing to pay or not paying the expected amount. The balance is your responsibility whether insurance pays or not.*

I have completed this form fully and completely; and certify that I am the patient or duly authorized agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment of services.

*Signature*____ *Date*____________________

Medical Health History

Do you have or have you had any of the following? Check all that apply

- ☐ **Are you required to pre-medicate before dental treatment?**
- ☐ Blood disorders
- ☐ Heart disease
- ☐ Heart attack or stroke
- ☐ Heart murmur, MVP, defect
- ☐ Pacemaker
- ☐ Joint replacement
- ☐ High blood pressure
- ☐ Tuberculosis
- ☐ Kidney problems
- ☐ Hepatitis
- ☐ Other liver problems
- ☐ Diabetes
- ☐ Epilepsy or seizures
- ☐ Neurological problems
- ☐ Thyroid problems
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV+
- ☐ Cancer or Tumors
- ☐ Chemo or radiation
- ☐ Abnormal bleeding
- ☐ Sinus, allergies or hayfever
- ☐ Asthma or emphysema
- ☐ Glaucoma
- ☐ Hiatial hernia
- ☐ Inflammatory disease
- ☐ Fainting spells
- ☐ Stomach or Intestinal problems
- ☐ Psychiatric problems
- ☐ STDs or VD
- ☐ Ulcers
- ☐ Rheumatic fever

Are you allergic to:

- ☐ Latex
- ☐ NSAIDS
- ☐ Antibiotics
- ☐ Codeine or other narcotics
- ☐ Local anesthetics
- ☐ Other:______________

Are you taking any of the following:

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Antibiotics
- ☐ HBP medication
- ☐ Antidepressants
- ☐ Insulin
- ☐ Steroids
- ☐ Osteoporosis medication
- ☐ Natural supplements
- ☐ Other

Women:

- ☐ Are you pregnant? If yes, how many months?____________

- ☐ Clenching or grinding
- ☐ Any other health problems or issues you want to make us aware of:

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I , the undersigned, affirm that the information above is accurate and complete to the best of my knowledge. I will not hold Dr. Stancill or any member of his staff responsible for errors or omissions that I have made in the completion of this form. I consent to any advisable and necessary endodontic treatment to be administered by Dr. Stancill or his supervised staff for diagnostic purposes or dental treatment. I realize that treatment is no guarantee of success and factors such as separated instruments, perforations, post-treatment inflammation, infection, paresthesia and tooth fracture may complicate the prognosis.

I understand that I am to return to my dentist for permanent restoration of the treated tooth.

Signature____ **Date**___________________________