PATIENT NAME:_____ DATE_____

DATE OF BIRTH _____ AGE_____

REFERRING DENTIST or CLINIC:_____

PHARMACY:_____

SPECK ENDODONTICS, LLC

PATIENT REGISTRATION AND HEALTH HISTORY • PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Please (circle) any of the following you have had or presently have:

Heart Failure	Drug Addiction	Hay Fever	Mitral Valve Prolapse
Heart Disease or Attack	Stroke	Allergies or Hives	Hemophilia
Angina Pectoris	Developmentally Disabled	Sinus Trouble	Anemia
Congenital Heart Disease	Swollen Ankles	Radiation Therapy	Sickle Cell Disease
Heart Murmur	Artificial Joint	Chemotherapy	Liver Disease
High Blood Pressure	Kidney Trouble	Cancer	Yellow Jaundice
Arteriosclerosis	Ulcers	Emphysema	Epilepsy or Seizures
Artificial Heart Valve	Diabetes	Prolonged Bleeding	Fainting or Dizzy Spells
Heart Pacemaker	Thyroid Problems	Hepatitis A (Infectious)	Nervousness
Heart surgery	Glaucoma	Hepatitis B	Psychiatric Treatment
Rheumatic Fever	Cosmetic Surgery	Hepatitis C (Chronic)	Shortness of Breath
Arthritis	Chronic Cough	AIDS	Lupus
Rheumatism	Tuberculosis	H.I.V. Positive	Dry Mouth
Cortisone Medicine	Asthma	Blood Transfusion	Herpes

_____

_____ NKDA NCAN CAN

EMERGENCY CONTACT:_____

Blood Pressure_____ Respiration_____

1. Do you have or have you had any disease or condition not listed? YES NO
   If yes, please list:_____
2. Are you having pain or discomfort at this time?_____ YES NO

Select a Number 0 to 10:_____

3. Have you been a patient in the hospital during the past two years? YES NO
4. Have you been under the care of a medical doctor during the past two years? Physician's Name_____ YES NO
   Phone Number_____
5. Are you now taking any medication, drugs or pills?_____ YES NO
   If yes, please list:_____
   _____
   _____
6. Are you aware of being allergic to or have you ever reacted adversly to any medication or substance? YES NO
   If yes, please list:_____
   _____
7. Reaction to local anesthetic? YES NO

Pregnant? YES NO What trimester?_____ Nursing? YES NO Birth control pills? YES NO

****** **COMPLETE OTHER SIDE** ******

PATIENT NAME _____ MALE _____ FEMALE _____

ADDRESS _____ DATE _____

CITY _____ STATE _____ ZIP _____

PHONE H (____) _____ C (____) _____ W (____) _____

DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY # _____-_____-_____

OCCUPATION _____ EMPLOYER _____

PRIMARY DENTAL INSURANCE

INSURANCE COMPANY _____ GROUP NAME _____

POLICY HOLDER'S NAME _____ ID # OR SS# _____

DATE OF BIRTH _____ GROUP # _____ EFFECTIVE DATE _____

SECONDARY DENTAL INSURANCE

INSURANCE COMPANY _____ GROUP NAME _____

POLICY HOLDER'S NAME _____ ID # OR SS# _____

DATE OF BIRTH _____ GROUP # _____ EFFECTIVE DATE _____

ACCOUNT INFORMATION – PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE H (____) _____ C (____) _____ W (____) _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____-_____-_____

EMAIL _____

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with the above mentioned patient. I understand that using anesthetic agents embodies a certain risk and endodontic instruments may separate. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Our office policy is to keep every patient's medical/dental and personal information private. It is our intention not to disclose any sensitive information to anyone other than medical/dental or insurance personnel working directly with this office related to your treatment. You may obtain a copy of the office policies at your request, or read them as posted in our waiting room. Your signature below acknowledges that you have been made aware of these policies, and will become a part of your permanent record in this office.

****** HIPAA AUTHORIZATION ******

4. I, _____ authorize employees of Speck Endodontics, LLC to release any or all dental / medical information to: _____ Phone: (____) _____

Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

Patient _____ Date _____

Parent or Responsible Party _____ Date _____

Relationship to patient _____ Witness _____

****** COMPLETE OTHER SIDE ******