# PATIENT REGISTRATION

☐ The following information is necessary for proper treatment and will be kept confidential in compliance with the Health Insurance Portability and Accountability Act. I have been given the opportunity to receive and review a copy of this office's *Notice of Privacy Practices.*
**(initial)**

**Patient's Name (Mr., Ms., Miss, Mrs., Dr.)** ______________________________

**Home Address**______________________________**City**______________**Zip**____________

**Home Phone**__________________ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐

**Birth Date**__________________ **Social Security #**________________

**Employed By**______________________________**Business Phone**________________

**Name of Spouse or Parent (if minor)**______________________**Soc.Sec.#**______________

**Spouse or Parent's Employer**________________________**Business Phone**______________

**Referring Dentist**____________________**How long have you been his/her patient?**_________**yrs.**

**Party Responsible for Account**__________________________**Relationship**______________

If your dental treatment is covered by insurance, please completely fill out the information below:

**Insurance Company**__________________________________ **Dental** ☐ **Medical** ☐

**Mailing Address**__________________________________ **Policy or ID #**______________

**Insured's Name**__________________________________**Birthdate**________________

Second Insurance:

**Insurance Company**__________________________________ **Dental** ☐ **Medical** ☐

**Mailing Address**__________________________________ **Policy or ID #**______________

**Insured's Name**__________________________________**Birthdate**________________

## HEALTH HISTORY

| | YES | NO |
|---|---|---|
| **1. Do you now have or have you ever had any heart trouble?** | ☐ | ☐ |
| **2. Have you ever had high or low blood pressure?** | ☐ | ☐ |
| **3. Do you have prosthetic heart valves or other heart repair?** | ☐ | ☐ |
| **4. Have you had any problems with bleeding?** | ☐ | ☐ |
| **5. Are you presently under the care of a physician?** | ☐ | ☐ |
| **6. Name of physician**______________________________ | | |
| **7. Have you ever been hospitalized for a serious illness?** | ☐ | ☐ |
| ______________________________ | | |
| **8. Have you ever had kidney disease, liver disease, or diabetes?** | ☐ | ☐ |
| **9. Have you ever had any problems during dental treatment?** | ☐ | ☐ |
| ______________________________ | | |

10. **List any medications you are presently taking or have taken during the past year:**

________________________________________________________________

________________________________________________________________

11. **CYVT\ any of the following that you are allergic to:**

**Aspirin** **Iodine** **Penicillin** **Codeine** **Novocain/Anesthetics**

**Latex** **Other Drugs**______________________________________________

12. **Check any of the following that you have had:**

| | | | | |
|---|---|---|---|---|
| **Glaucoma** | **Cancer** | **Heart Attack** | **Injury to Face/Jaws** | **Osteoporosis** |
| **Hepatitis** | **Ulcers** | **Stroke** | **Blood Transfusion** | **Shingles** |
| **Seizures** | **Asthma** | **Arthritis** | **Sinus Trouble** | **Tuberculosis** |
| **Fainting** | **Herpes** | **AIDS/HIV** | **Venereal Disease** | |

| | **YES** | **NO** |
|---|---|---|
| **13. Do you have artificial joints?** | ☐ | ☐ |
| **14. Should you routinely pre-medicate with antibiotics prior to dental visits?** | ☐ | ☐ |
| **15. Women: Do you take birth control pills?** | ☐ | ☐ |

16. **Women: Are you pregnant? _________ Which month? __________**

17. **Please list any other health problems not indicated above:**

______________________________________________________________________________

## PAYMENT

Endodontic services are offered on a cash basis payable during and/or upon completion of services. We will gladly bill your insurance company but you are responsible for any balance not paid by them and must clear your bill within 30 days of service.

## CONSENT FOR ROOT CANAL TREATMENT AND LOCAL ANESTHETIC

After consultation with the Doctor, I, the undersigned, being the patient or parent/guardian of the above named patient, consent to procedures which may be determined necessary by the Doctor.

I authorize and request the administration of such drugs and/or anesthetics as may be deemed advisable by the Doctor. I also understand that upon completion of root canal therapy in this office, I will be referred to my dentist for a permanent restoration, such as an onlay, crown or filling.

A finance charge of 1.5% per month (APR 18%) will be assessed on any past due balance. In the event of non-payment, I am responsible for all collection costs, collection agency fees (33-50%), and attorney fees.

Furthermore, I declare that the information given on this form is true and complete to the best of my knowledge. I give permission for this information to be disclosed to obtain payment from my insurance company or to facilitate treatment by my dentist or medical doctor.

Patient Signature/
Responsible Party__________________________________________Date________________________

Witness_________________________________________________Date________________________

TROY THOMSON, DDS, MS
MATTHEW KJAR, DMD, MS