

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 (initial) review a copy of this office's *Notice of Privacy Practices*.

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had high or low blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have prosthetic heart valves or other heart repair? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any problems with bleeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you presently under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Name of physician _____ | | |
| 7. Have you ever been hospitalized for a serious illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | |
| 8. Have you ever had kidney disease, liver disease, or diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had any problems during dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | |

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

11. CYY\ 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