LOWER GWYNEDD
ENDODONTICS

DENTAL REGISTRATION AND HEALTH HISTORY

Date_____

Patients Name_____ **How do you prefer to be addressed?**_____

Sex: M F Age:_____ **Birth Date:**_____/_____/_____ **SS#**_____-_____-_____

Mailing Address_____ **City**_____ **State**_____ **Zip**_____

Home #:_____ **Cell#:**_____ **Work#:** _____

Employer:_____ **Occupation:** _____

If Student, name of School / College:_____ **City**_____ **State**_____ **Part Time or Full Time**

Email Address:_____ **Whom may we thank for referring you to our office:**_____

If the person responsible for this patients account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Name of responsible party_____ **Relationship to Patient**_____

Mailing Address_____ **City**_____ **State**_____ **Zip**_____

Sex: M F Age:_____ **Birth Date:**_____/_____/_____ **SS#**_____-_____-_____

Home #:_____ **Cell#:**_____ **Work#:**_____

Email Address:_____ **Employer:**_____ **Occupation:**_____

INSURANCE INFORMATION

Policy Holders Name_____ **Relationship to Patient**_____

Social Security and/or Member ID #_____ **Date of Birth**_____/_____/_____

Name of Employer_____ **Employer Address**_____

Insurance Co._____ **Phone #_(**_____**)**_____-_____ **Group #**_____

Secondary Insurance Information

Policy Holders Name_____ **Relationship to Patient**_____

Social Security and/or Member ID #_____ **Date of Birth**_____/_____/_____

Name of Employer_____ **Employer Address**_____

Insurance Co._____ **Phone #_(**_____**)**_____-_____ **Group #**_____

Answers to the following questions are for our records only and will be considered confidential.

ALLERGIES **MEDICATIONS**

Aspirin	**Local Anesthetic**
Barbiturates	**Penicillin**
Codeine	**Sulfa**
Iodine	**Metals**
Latex	**Other:_____**

Please list any medications you are currently taking: _____

Place a mark on YES or No to indicate if you have had any of the following:

Chest Pain	**YES**	**NO**	**Hepatitis A (Infectious)**	**YES**	**NO**	**Use of tobacco products**	**YES**	**NO**
Heart Failure	**YES**	**NO**	**Hepatitis B (Serum)**	**YES**	**NO**	**Drug addictions**	**YES**	**NO**
Heart Disease or Attack	**YES**	**NO**	**Hepatitis C or other**	**YES**	**NO**	**Alcoholism**	**YES**	**NO**
Osteoprosis/osteopenia	**YES**	**NO**	**Tuberculosis (TB)**	**YES**	**NO**	**Psychiatric Treatment**	**YES**	**NO**
Heart Surgery	**YES**	**NO**	**HIV positive, ARC, AIDS**	**YES**	**NO**	**Bisphosphonate**	**YES**	**NO**
***Mitral Valve Prolapse**	**YES**	**NO**	**Sickle Cell Disease**	**YES**	**NO**	**Birth Defects**	**YES**	**NO**
***Congenital Heart Problems**	**YES**	**NO**	**Emphysema**	**YES**	**NO**	**Eating Disorder**	**YES**	**NO**
***Heart Murmur**	**YES**	**NO**	**Diabetes**	**YES**	**NO**	**Fainting or dizzy spells**	**YES**	**NO**
High Blood Pressure	**YES**	**NO**	**Liver Disease**	**YES**	**NO**	**Epilepsy or seizures**	**YES**	**NO**
Heart Pacemaker	**YES**	**NO**	**Thyroid Disease**	**YES**	**NO**	**Persistent Cough**	**YES**	**NO**
Stroke	**YES**	**NO**	**Kidney Trouble**	**YES**	**NO**	**Asthma**	**YES**	**NO**
Cancer (Type:)	**YES**	**NO**	**Hemophilia**	**YES**	**NO**	**Shortness of Breath**	**YES**	**NO**
Radiation Therapy	**YES**	**NO**	**Jaundice**	**YES**	**NO**	**Hay Fever**	**YES**	**NO**
Chemotherapy	**YES**	**NO**	**Anemia**	**YES**	**NO**	**Hives or Skin Rash**	**YES**	**NO**
***Steroid Treatment**	**YES**	**NO**	**Glaucoma**	**YES**	**NO**	**Sinus Trouble**	**YES**	**NO**
***Artificial Joints**	**YES**	**NO**	**Arthritis**	**YES**	**NO**	**Herpes**	**YES**	**NO**
***Any Type of Transplant: Type**	**YES**	**NO**	**Ulcers**	**YES**	**NO**	**Cold Sores**	**YES**	**NO**
***Any Type of Implant: Type**	**YES**	**NO**	**Angina Pectoris**	**YES**	**NO**	**Bruise Easily**	**YES**	**NO**
***Rheumatic Fever**	**YES**	**NO**	**Blood Transfusion**	**YES**	**NO**			

OTHER:_____

***Antibiotic pre-medication may be required prior to your appointment**

Have you been advised by your Physician to "Pre-Medicate" for dental appointments? YES NO

WOMEN: Are you pregnant now?	**YES**	**NO**	**If yes, what is your due date?**_____
Are you currently breast feeding?	**YES**	**NO**	
Are you taking oral contraceptives?	**YES**	**NO**	

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group 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 my dependents.

Signature of patient or guardian _____

_____

Signature of Dentist

Date:_____