

Patient Registration and Health History Form

Please use black pen only. On future visits please be sure to update your medical history.

Patient Information

Mr. Ms. Mrs. Dr. First name _____ M. I. _____ Last name _____

Sex: M F Date of birth: / / Email: _____

Street: _____

City: _____ State: _____ Zip: _____

Phones: Home: _____ Business: _____ Cell: _____

General dentist: _____ Referred by: _____
(First and last name) (Please write "same" if referred by general dentist)

Other dental specialists you see (i.e., periodontist): _____

Physician: _____ Phone: _____

Emergency Contact

In case of emergency contact: _____ Spouse Father Mother Other

Phones: Home: _____ Business: _____ Cell: _____

Reason for Visit

What is the reason for your visit today?

How long have you had this problem?

What are your symptoms?

Medical History

Please answer the following questions to the best of your knowledge. Although endodontists primarily treat the mouth area, medical problems or medications could have a significant impact on your dental treatment. Your answers are confidential.

Y N Are you in good health? Height: _____ Weight: _____

Y N Are you under the care of a physician? Date of last physical examination: _____

Y N Have you had any illness, operation, or been hospitalized in the past five years? _____

Y N Prosthetic joint implant _____	Y N Emphysema	Y N Bisphosphonates: Fosamax, AcetoneI, Aredia, Boniva, Zometa, and Didronel
Y N Heart valve replacement or vascular graft	Y N Parkinson's disease	Y N Arthritis/joint disease
Y N Damaged heart valves/prosthetic valve	Y N Smoking/chewing tobacco	Y N Stomach ulcers/GERD
Y N Heart attack(s)/myocardial infarction (MI)	Y N Blood transfusion	Y N Irritable bowel syndrome
Y N Irregular heart beat/tachycardia	Y N Blood disorder/anemia	Y N Contagious diseases
Y N High blood pressure	Y N Bruise easily	Y N Delay in healing
Y N Low blood pressure	Y N A history of drug abuse	Y N Anemia
Y N Chest pain/angina	Y N Eye disease/glaucoma	Y N Tumor/ growth
Y N Mitral valve prolapse/heart murmur	Y N Abnormal bleeding	Y N Breast surgery of any type
Y N Rheumatic Fever/Rheumatic Heart Disease	Y N Hepatitis/jaundice/liver disease	Y N Radiation/chemotherapy/cancer
Y N Cardiac pacemaker	Y N HIV/AIDS/STD	Y N Are you on a diet
Y N Heart surgery/bypass surgery	Y N Infectious mononucleosis	Y N Immune system problems
Y N Stroke/Transient Ischemic Attack (TIA)	Y N Gallbladder trouble	Y N Malignant hyperthermia
Y N Convulsions/epilepsy	Y N Fainting spells	Y N History of alcohol abuse
Y N Bronchitis/chronic cough	Y N Thyroid trouble	Y N Chronic fatigue
Y N Asthma	Y N Diabetes	Y N Mental health problems
Y N COPD	Y N Swollen ankles/joint disease	Other _____
Y N Respiratory problems	Y N Low blood sugar	
Y N Tuberculosis	Y N Kidney trouble	
	Y N Are you on dialysis	

Medications

Are you taking any of the following medications (please circle)?

<i>Blood thinner:</i> Coumadin (Warfarin)	Alpha-adrenergic blockers, phenoxybenzamine, prazosin
Ephedra, yohimbe <i>herbals</i>	Levodopa, thyroid hormones: levothyroxine, liothyronine
<i>Antipsychotic,</i> haloperidol, thioridazine	Beta-adrenergic blockers, nonselective, <i>antiarrhythmic agent, Class II,</i> dorzolamide/timolol, levobunolol, metipranolol, nadolol, nadolol/bendroflumethiazide, propranolol, sotalol, timolol
Catechol-O-methyltransferase inhibitor	CNS stimulants: amphetamine, methylphenidate, ergot derivatives: dihydroergotamine, methysergide
<i>Congestive Heart Failure/Arrhythmia</i>	Digitalis: digoxin, digitoxin
Cocaine	Methyldopa, adrenergic neuronal blocking drugs: guanadrel, guanethidine, reserpine
MAO <i>antidepressant</i>	Tricyclic <i>antidepressants</i> amitriptyline, amoxapine, clomipramine, desipramine, doxepin, imipramine, nortriptyline, protriptyline, trimipramine Maprotiline

Please list all medications you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Allergies

Y N Penicillin, Amoxicillin, Augmentin Y N Aspirin, Advil, Motrin, Ibuprofen Y N Sulfa/sulfites Y N Other antibiotics Other _____	Y N Valium or other tranquilizers Y N Local anesthetic (novocaine, adrenalin) Y N Codeine or other narcotics Y N Latex Other _____
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Women

- Y N Are you pregnant? If yes, estimated delivery date: _____
- Y N Is there a possibility of pregnancy?
- Y N Are you nursing?
- Y N Are you taking birth control pills? (Antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control if antibiotics are prescribed.)

All Patients

- Y N Have you been told by your physician to take antibiotics prior to dental treatment?
- Y N Is there any health condition about which the doctor should know?
- Y N Do you wish to speak to the doctor privately about anything?

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my endodontist, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I understand that I am responsible for notifying my endodontist of any medical changes upon each visit.

Patient Signature: X

(Parent or Guardian if minor)

Date: X

Authorization

I authorize my endodontist and his/her staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. If medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Patient Signature: X

(Parent or Guardian if minor)

Date: X

Doctor: X

Witness: X

Acknowledgement of Receipt of Notice of Privacy Practices

The doctors and staff at The Virginia Endodontic Group, LLC will use and disclose your personal health information to treat you and to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution. You may refuse to sign this acknowledgement.

Patient Signature: X

(Parent or Guardian if minor)

Date: X