INDIANA ENDODONTICS Incorporated

Patient Registration

Thank you for choosing Indiana Endodontics for your endodontic needs. We are dedicated to making your experience at our office as pleasant as possible. We have made our patient registration forms available for you to complete prior to your visit for your convenience. Please follow one of the options below.

- Download form -> Fill out form -> Email to info@indianaendo.com
- Download form -> Print form -> Fill out form -> Bring to appointment
- Fill out forms in our office prior to your appointment

Whatever is easiest for you is great for us.

Thanks again and we look forward to seeing you soon!

Download | Print | Email Form | Clear Form

INDIANA ENDODONTICS Incorporated

Patient Registration

Todays Date: _____

Patient Information

Prefix: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev. ☐ Sex: Male ☐ Female ☐

Patients Name: FIRST _____ MIDDLE _____ LAST _____

Address: STREET _____ CITY _____ STATE _____ ZIP CODE _____

Date of Birth: _____ Social Security No: _____ Employer: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email: _____ Drivers License No: _____

Emergency Contact: FIRST _____ LAST _____ Phone: _____

Relation to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐ _____

Preferred Pharmacy: _____ Phone: _____

Dentist: _____ Phone: _____

Physician: _____ Phone: _____

Responible for Payment: FIRST _____ LAST _____ Same Address: Y ☐ N ☐

Address: STREET _____ CITY _____ STATE _____ ZIP CODE _____

Whom may we thank for your referral? Dentist ☐ Other ☐ _____ No Referral ☐

Dental Insurance Coverage Information

Primary Dental - Carrier Name: _____ Is the subscriber the patient? Y ☐ N ☐

Subscriber Name: FIRST _____ LAST _____ Date of Birth: _____

Subscriber ID: _____ Group No: _____ Social Security No: _____

Subscriber Phone: _____ Relation to Patient: Spouse ☐ Parent ☐ Other ☐

Subscriber Employer: _____

Address: STREET _____ CITY _____ STATE _____ ZIP CODE _____

Secondary Dental - Carrier Name: _____ Is the subscriber the patient? Y ☐ N ☐

Subscriber Name: FIRST _____ LAST _____ Date of Birth: _____

Subscriber ID: _____ Group No: _____ Social Security No: _____

Subscriber Phone: _____ Relation to Patient: Spouse ☐ Parent ☐ Other ☐

Subscriber Employer: _____

Address: STREET _____ CITY _____ STATE _____ ZIP CODE _____

Patient Information

Patients Name: FIRST _____ MIDDLE _____ LAST _____

Age: _____ Weight: _____ Date of Birth: _____

Allergies *(check all that apply)*

Penicillin ☐ Amoxicillin ☐ Local Anesthetic ☐ Aspirin ☐ Sulfa Drugs ☐ Ibuprofen ☐ Sulfites ☐

Codeine ☐ Latex ☐ Clindamycin ☐ Halcion/Anti-Anxiety ☐ Other ☐ _____

Medical History *(check all that apply)*

Cardiovascular

High Blood Pressure ☐

Heart Attack ☐

If so, when? _____

Angina Chest Pain ☐

If so, when last? _____

Take Daily Aspirin ☐

Coumadin/Blood Thinners ☐

Heart Murmur ☐

Artificial Heart Valve ☐

Mitral Valve Prolapse ☐

Rheumetic Fever ☐

Congenital Heart Defect ☐

Irregular Heart Beat ☐

Heart Pace Maker ☐

Heart Surgery ☐

If so, when? _____

Other Heart Problems ☐

What? _____

When? _____

Dermal/Muscoloskeletal

Sore Jaw Muscles/Joints ☐

Arthritis ☐

Artifical Joints ☐

Mouth Ulcers/Sores ☐

Skin Rash/Hives ☐

Nerves & Sensory

Severe Headaches ☐

Fainting/Dizzy Spells ☐

Angina/Chest Pains ☐

Epilepsy/Seizures ☐

Nervousness ☐

Other ☐

Respiratory (breathing)

Sinus Problems ☐

Allergies or Hives ☐

Asthma ☐

Use Inhaler? Y ☐ N ☐

How Often? _____

Is it with you? Y ☐ N ☐

Turberculosis ☐

Shortness of Breath ☐

Endocrine (hormonal)

Diabetes ☐

Take Insulin? ☐

A1C: _____

Thyroid Disease ☐

Other Conditions

Enlarged Node/Glands ☐

Use Tobacco ☐

Use Alcohol ☐

Cancer/Chemo/Radiation ☐

Gastrointestinal (stomach)

Ulcers ☐

Hepatitis ☐

When? _____

If so, type? _____

Liver Disease ☐

Cirrhosis ☐

Hematologic (blood)

Stroke ☐

If so, when? _____

Anemia/Hemophelia ☐

Prolonged Bleeding ☐

Leukemia ☐

HIV/AIDS Positive ☐

Bruise Easily ☐

Urinary

Urinate Frequently ☐

Kidney Problem ☐

Kidney Disease ☐

Dialysis ☐

If yes, what days? _____

Other Not Listed

Women *(check all that apply)*

Taking birth control pills? ☐ Are you nursing? ☐ Are you pregnant? ☐ Due Date: _____

Dental Information *(check all that apply)*

Reason for Todays Visit: _____

Recent Dental Work? please briefly explain: _____

Recent Oral Surgery	☐	Tooth Sensitivity to Hot/Cold	☐	Anxious	☐
Recent Swelling	☐	Trauma to Teeth Current/Past	☐	Headaches/Neck Pain	☐
Biting Pain	☐	Difficult to Numb	☐		

Medication Information

- Have you been instructed to **premedicate with antibiotics** prior to treatment for any health related conditions?

Such as MVP, Artificial joints, Rheumetic Fever, Murmurs, Heart Defects, Etc. Y ☐ N ☐

- Are you or have you taken a **blood thinner**? Y ☐ N ☐
- Are you or have you taken a **bisphonsphonate** drug? Y ☐ N ☐

Please list all medications you currently take:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

If you have dental insurance, we will be happy to assist you in processing your claims for benefits to which you are entitled. You must realize the insurance company has an obligation to you and not to the dentist. I accept full financial responsibility for the treatment performed by this office. I agree to pay all costs of collections including attorney fees and court costs. At the time services are rendered payment is expected unless other arrangements are made.

Patient (guardian): _____ Date: _____
SIGNATURE

I hereby acknowledge a copy of the office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

Patient (guardian): _____ Date: _____
SIGNATURE

I understand and attest the information I have given today is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, including x-rays. I understand that the treatment has no guarantee of success and that complications, which may result in tooth loss or the necessity for further treatment, may occur. I also understand that I am to return to my dentist for a permanent restoration, no later then a month, following the completion of my root canal therapy.

Patient (guardian): _____ Date: _____
SIGNATURE