**ENDODONTIC SPECIALISTS OF MADISON, S.C.**

# REGISTRATION AND HEALTH HISTORY

PLEASE PRINT

Date ___/___/___ Name _____ ☐ FEMALE ☐ MALE

First, MI, Last (Circle - Ms., Mrs., Miss, Mr., Dr.)

Address _____

Number and Street City State Zip

Home phone number _____ Work / Cell number _____

Date of Birth _____/_____/_____ Social Security Number _____-_____-_____

(If necessary for Insurance)

Employer / Occupation _____

Person to contact in case of emergency _____ Phone _____

If patient is a minor, give name of: Mother _____ Father _____

Guardian _____

Who referred you to this office? _____

Who is your regular (family) dentist? _____

Dental Insurance Carrier _____ Medical Insurance Carrier_____

## MEDICAL HISTORY

In the following sections, circle yes or no, fill in the blank, or check the appropriate answer. Your answers are for our records only, and will be considered confidential.

Do you pre-medicate for any medical reason? Yes _____ No _____

Explain: _____

Has there been any change in your general health within the past year? Yes _____ No _____

Are you now under the care of a physician? Yes _____ No _____

If so, what is the condition being treated? _____

The name and address of my physician/clinic is _____

Date of your last physical examination _____

What is your blood pressure? _____ When was it last checked? _____

Have you had any condition, illness, or operation for which you have been hospitalized or treated within the last 5 years?

Yes _____ No _____

If so, what was the illness or operation? _____

Women: ☐ Are you, or do you think you may be pregnant?

☐ Are you nursing?

(OVER)

DO YOU HAVE OR HAVE YOU EVER HAD: (Please circle if yes.)

- ☐ Allergies
- ☐ Anemia or Blood Disorder
- ☐ Abnormal Bleeding
- ☐ TMJ/TMD
- ☐ Asthma or Hay Fever
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting Spells/Seizures
- ☐ Hepatitis/Jaundice/Liver Disease
- ☐ Kidney Trouble
- ☐ Prosthetic Devices:
  Hip or Joint ____ Heart Valve ____
- ☐ Sinus Condition
- ☐ Stomach Ulcers/Intestinal Problems
- ☐ Thyroid Condition
- ☐ Stroke/CVA/TIA
- ☐ AIDS/HIV
- ☐ Tuberculosis
- ☐ Osteoporosis
- ☐ Malignancies (Cancer):
  - ☐ Radiation Therapy
  - ☐ Chemotherapy

Abnormal Heart Conditions:

- ☐ Pacemaker
- ☐ Angina
- ☐ Bypass Surgery
- ____ Mitral Valve Prolapse
- ____ Artificial Heart Valve
- ☐ Chest Pain
- ☐ Heart Murmur/Rheumatic Fever
- ____ Heart Attack (MI)
- ☐ Coronary Insufficiency

Do you have any diseases, condition, or problem not listed above that you think we should know about?
If so, please explain. _____

_____

Are you taking any of the following? (Please check if yes.)

- ☐ Antibiotics or sulfa drugs
- ☐ Medicine for high blood pressure
- ☐ Tranquilizers/Antidepressants
- ☐ Digitalis or drugs for heart trouble
- ☐ Oral contraceptives/hormonal therapy
- ☐ Anti-coagulants
- ☐ Antihistamines
- ☐ Cortisone (steroids)
- ☐ Aspirin/Tylenol/Ibuprofen
- ☐ Nitroglycerin
- ☐ I.V. Bisphosphonates (past or present use)

Names and dosages of medications now being taken: _____

_____

_____

_____

| Are you allergic or have you reacted adversely to: | | If Yes, explain / list: |
|---|---|---|
| Local anesthetics (novocaine) | ☐ Yes ☐ No | _____ |
| Penicillin or other antibiotics | ☐ Yes ☐ No | _____ |
| Aspirin/Ibuprofen/Tylenol | ☐ Yes ☐ No | _____ |
| Codine or other narcotics | ☐ Yes ☐ No | _____ |
| Bisulfite (salad bars) | ☐ Yes ☐ No | _____ |
| Latex | ☐ Yes ☐ No | _____ |

I consent to Endodontic Specialists of Madison S.C.'s use and disclosure of my records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records to the following persons who are involved in my care or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing. I understand that payment is due upon receipt of treatment*. I also understand that if I have dental insurance, a 25%-50% deposit is required at time of treatment. It is also understood that my dental insurance carrier may pay less than the actual bill for services and that I am financially responsible for payment in full of all accounts within the limit of this office's credit policy (90 days from date of treatment). By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I understand the information I have given today is correct to the best of my knowledge. I also understand and accept my responsiblity to inform this office of any changes in my medical status.

_____
Patient, Parent or Guardian's Signature Date

_____
Address (if different) Phone

*For non-insured patients, or those owing balances after insurance payments have been received, we accept Visa and MasterCard, as well as a monthly payment plan (interest-free).

06/11