NEW ALBANY
ENDODONTICS
ROOT CANAL SPECIALISTS

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PATIENT REGISTRATION

Patient Information

Patient's Name _____ ❑ Male ❑ Female DOB _____

Street Address _____ SS# _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

email _____ May we leave a message? ❑ Phone ❑ email

In case of emergency, notify _____ Phone _____

General Dentist _____

Responsible Party Information (Parent or Guardian)

Responsible Party Name _____ DOB _____

Street Address _____ SS# _____

City _____ State _____ Zip _____ Phone _____

Relationship to Patient _____

PERSONAL AND MEDICAL HISTORY

Have you ever had or do you presently have any of the following?

AIDS or HIV positive	❑	**Heart Murmur**	❑
Allergies or Hives	❑	Heart Pacemaker	❑
Artificial Heart Valve	❑	Heart Surgery	❑
Artificial Joint(s) (Year _____)	❑	Hepatitis A / B / C	❑
Asthma	❑	High Blood Pressure	❑
Bleeding Problems	❑	Kidney Disease	❑
Bruise Easily	❑	Mitral Valve Prolapse	❑
Cancer	❑	Nervous Disorders	❑
Diabetes	❑	Rheumatic Fever	❑
Drug Addiction	❑	Sinus Problems	❑
Emphysema	❑	Stroke	❑
Endodontic Therapy (Root Canal)	❑	Thyroid Disease	❑
Epilepsy or Seizures	❑	Tuberculosis	❑
Glaucoma	❑	Ulcers	❑
Hay Fever	❑		
Heart Attack	❑	None of the Above	❑

CONTINUED ON BACK

PATIENT REGISTRATION / PERSONAL AND MEDICAL HISTORY (cont)

Have you ever been told by your physician that you need to premedicate with an antibiotic before dental treatment because of a medical condition, i.e. heart, artificial joint, etc.?

YES ❑ NO ❑

If YES, did you take an antibiotic premedication for today's visit?

YES ❑ NO ❑

Are you allergic or have you reacted adversely to any of the following?

Aspirin	❑	Local Anesthetic	❑
Clindamycin	❑	Penicillin	❑
Codeine	❑	Sulfa	❑
Erythromycin	❑	Tylenol	❑
Household Bleach	❑	Valium	❑
Ibuprofen	❑		
Latex (Rubber)	❑	None of the Above	❑

Additional Allergies _____

_____

_____

_____

If applicable:

Are you pregnant? YES ❑ NO ❑

Breast Feeding? YES ❑ NO ❑

List ALL medications you are currently taking including herbal remedies:

Drug name	Reason for taking	Dose

Any other medical or dental information that you feel the doctor should be aware of?

_____

_____

_____

_____

_____

_____

_____

Acknowledgment of Financial Responsibility and/or Assignment of Benefits

I agree to pay in full any unpaid balance on my account, regardless of insurance. I hereby authorize and direct my insurance company to issue payment directly to New Albany Endodontics for all services rendered to me.

PRIVACY POLICY

We collect personal and health information to effectively deliver endodontic services. We treat non-public information about our patients as confidential. All employees are trained and required to protect this information, and we maintain the highest standards to safeguard your personal information. If you would like more information about our privacy policy, please ask for a copy of our Healthcare Privacy Statement..

The undersigned acknowledges that he or she has read and/or has been offered the opportunity to read the privacy policy, and authorizes the release of any pertinent information relating to my treatment.

Patient/Guardian Signature _____ Date _____