Registration Form
(please print)

San Antonio ENDODONTICS

Today's Date:	PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital Status ☐ Single ☐ Div ☐ Wid ☐ Mar ☐ Sep

Date of Birth: / /	Sex ☐ M ☐ F	Social Security no.:	Home phone: ( )	Cell phone: ( )

Street address:	City:	State: ZIP Code:

Referring Dr.	Family Physician Phone: ( )	Home E-Mail Work E-Mail

Occupation	Employer	Employer phone: ( )

Other family members seen here:	DL #:

INSURANCE INFORMATION
(Please give your insurance card to the receptionist.)

Person responsible for bill:	Date of Birth: / /	Address (if different):	Home phone: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No	Subscriber's name:

Subscriber's S.S. no.:	Date of Birth: / /	Group no.:	Policy no.:	Co-payment $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to San Antonio Endodontic Associates. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/parent/legal representative signature _____ Date / /

ENDODONTIC LIMITED MEDICAL HISTORY FORM

San Antonio ENDODONTICS

PATIENT NAME _____ **Are you currently seeing a physician?** ☐ **Yes** ☐ **No**

Name of Physician: _____ **Contact Phone:** _____

Do you have or have you had any of the following? (Please check)

	No	Yes	Comment
Latex Allergy			
Please list all allergies to Medications or Anesthesia, if any:			
Coronary Artery Disease			
Heart Valve Replacement			
Endocarditis			
Heart Surgery			
Congenital Heart Problem or Defect			
High Blood Pressure			
Osteoporosis/Osteopenia			
Have you taken any of these bisphosphonates: Pamidronate (APD, Aredia); Neridronate (Nerixia); Olpadronate; Alendronate (Fosamax); Ibandronate (Boniva); Risendronate (Actonel); Zoledronate (Zometa, Aclasta)			
Artificial Joint Replacement			
Liver Problem or Hepatitis			
Immune System Deficiencies			
HIV			
Stroke			
Bleeding Problem			
Anemia			
Asthma			
Diabetes			
Tuberculosis			
Lung Problem			
Neurological Problem			
Emotional Problem			
Thyroid Problem			
Cancer			
Radiation or Chemotheraphy			
Kidney Problem			
Intestinal Problem			
Endocrine Disorder			
Are there any other conditions or problems not listed above?			
FEMALE ONLY: are you currently Pregnant or Nursing now? If yes, how far along are you?			

Please list any medications that you are currently taking and the reasons for taking the medications:

_____

_____

_____ / / _____

Patient/parent/legal representative signature **Date** **Relationship to patient**