

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.	Preferred Pharmacy: Address:		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: NAME:		Date of Birth: SSN:			
Address: (If different)			Subscriber's name:		
Is this patient covered by insurance? ☐ Yes ☐ No			Subscriber's SSN/Member ID:		
Date of Birth:	Insurance Name:	Telephone#:		Group no.:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other					
Name of secondary insurance (if applicable):		Subscriber's name:	Subscriber's DOB:		SSN/ID#:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			Group no.:		
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/Guardian Signature

Date

David L. Cloutier, DMD & Associates

San Antonio Endodontics // www.sanantonioendo.com // 210-341-8281 // Blanco & 410

ENDODONTIC LIMITED MEDICAL HISTORY FORM



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	Medication/Dose Taken
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 Chemotherapy			
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 other medications that you are currently taking and the reasons for taking the medications:

Please list any surgeries and hospitalizations:

Patient/Guardian Signature

Date

Relationship to patient: