Endodontists

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Patient Registration
Drs. Rodriguez, and Trevino Welcome You

Root canal therapy is an attempt to save a tooth which otherwise may require extraction. We need certain information about you to make treatment as safe and successful as possible. Please read and fill out both sides carefully. If you have questions, be sure they are answered before signing this form.

Name _____ Home Phone _____ Cell Phone _____

Address _____ Apt# _____ City _____ State _____ Zip _____

Soc. Sec. No. _____ Birth date _____ Driver's Lie. No. _____

Exp. _____ Email _____

If minor, Guardian's name _____ Birth date _____ Relationship _____

Dental Insurance: Yes ○ No ○ (circle one) BCBS ofTX ○ MetLife ○ Aetna ○ Humana ○ Delta Dental ○ Guardian ○ Ameritas ○ Other

Name of Employer _____ Dept. _____ Work Phone _____ Ext _____
(If under 18 parent/guardian information)

Employer's Address. _____ E-MAIL address _____

Spouse Name _____ DOB: _____ Cell Phone: _____

Spouse's Employer _____ Employer's Address _____

Person to contact in case of an emergency _____ Phone _____

Whom may we thank for referring you? _____

Medical History: please make a check mark whether you now have or have ever been treated for:

☐ AIDS/HIV Positive	☐ Chest Pain	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Anemia
☐ Anemia	☐ Convulsions	☐ Hay fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Hearl Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/ Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Hearl Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care (emotional disorder)	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or growths
☐ Bruise Easily	☐ Fainting Spells/Dizzy	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcer
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

General health (make a check mark): Excellent ○ Good ○ Fair ○ Poor ○

Name of Physician _____ Date of last Physical examination _____

Any major change in health during the past year? ○ Yes ○ No

Do you have any other medical problem(s) not listed above? ○ Yes ○ No _____

Circle if you are allergic to: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Local anesthetic ☐ other _____

Allergies to any other medications, not listed above? _____

Please list below any medications you are presently taking: (Name, for what condition?)

Explain in your words the reason of today's visit _____

Is your visit due to an accident? ◯ Yes ◯ No If yes, please explain and date of accident _____

AN X-RAY(S) IS NECESSARY TODAY, TO ESTABLISH A COMPLETE DIAGNOSIS.
Where does it hurt? ☐ Right ☐ Left ☐ Upper ☐ Lower Have you had this problem (or similar problem) before? ◯ Yes ◯ No

On scale of 0-10, where would you rate you discomfort? (10 = most discomfort) _____
Is it a sharp pain or is it more like a dull ache? ☐ sharp ☐ dull
Does it throb, hurt, or is it more of a steady unchanging pain? ☐ throb ☐ hurt ☐ steady
Does it hurt all the time or does it start and stop? ☐ all time ☐ start & stop

Does it interfere with your sleep?	◯ Yes	◯ No	
Does anything make the pain worse?	◯ Yes	◯ No	What? _____
Have you taken aspirin or any other medication?	◯ Yes	◯ No	
Does the medication help?	◯ Yes	◯ No	

Consent Form:

I have reviewed the health history and believe it to be correct. If there is a change in health or in medications taken, I will inform the doctor at my next appointment. I consent to treatment by the health care providers of this dental practice.

Patient's signature (Parent's if minor) _____ Date_____

Doctor's signature_____ Date_____

Assistant's initials

CONSENT TO RECEIVING PRIVACY NOTICE
ASSIGNMENT OF INSURANCE BENEFITS CONSENT
FOR EVALUATION

I was given the opportunity to read the Privacy Notice and object to disclosures of my protected health information.

I authorize that I am financially responsible for all charges whether or not paid by insurance.

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on
all insurance submissions.

I authorize the dentist to release all information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I permit a copy of this authorization to be used in place of the original.

Patient signature _____ Date _____
(If under 18 parent/guardian signature)

Woman Only

Are you presently pregnant? ◯ Yes ◯ No Are you presently taking oral contraceptives? ◯ Yes ◯ No If so, read and sign the following:

Information and consent form patients taking oral contraceptives
It has been explained to me, and I understand, that oral antibiotics (and certain other medications) may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control for one complete cycle of birth control pills after my course of antibiotics or other medication is completed.

PATIENT'S SIGNATURE _____ DATE._____