REGISTRATION INFORMATION

Date_____ **Home Phone** (_____)_____

Cell Phone (_____)_____

Work Phone (_____)_____

PATIENT INFORMATION

(Please print all information)

Name_____ **ID/SS#**_____
(Last Name) (First Name) (Middle Initial)

Address_____
(Street and Number) (Apt. Number) (City) (State) (Zip)

Sex: ڤ M ڤ F Age_____ **Birth date**_____ ¤ **Married ڤ Single ڤ Minor ڤ Other**

Employer/School_____ **Occupation**_____

In case of Emergency who should be notified?_____ **Phone #** (____)_____

PRIMARY INSURANCE INFORMATION

Person Responsible for Account_____
(Last Name) (First Name) (Middle Initial)

Relation to Patient_____ **Birth date**_____ **ID/SS#**_____

Address & Phone (if different from patient's)_____
(Address) (Phone Number)

Employer & Occupation (if different from patient's)_____

Insurance Company:_____ **Group#**_____ **Subscriber#**_____

SECONDARY INSURANCE INFORMATION

Subscriber Name_____ **Relation to Patient**_____ **Birth date**_____

Subscriber Employed by_____ **Phone** (____)_____

Insurance Company_____ **Group#**_____ **Subscriber#**_____

DENTAL HISTORY

Referring Dentist_____
(Last Name) (First Name) (Name of Practice if different from Dr.'s Name)

Address_____ **Phone#** (____)_____

Reason for today's visit_____

Are you in Pain? ڤ Yes ڤ No **Have you experienced any swelling around this tooth? ڤ Yes ڤ No**

Check (√) if you have problems with any of the following:

ڤ Sensitivity to cold ڤ Sensitivity to hot ڤ Sensitivity to sweets ڤ Sensitivity when biting

MEDICAL HISTORY

Physician's name_____ Date of last visit_____

Have you had any serious illnesses or operations? ڤ Yes ڤ No If yes, describe_____

(Women) Are you pregnant? ڤ Yes ڤ No Nursing? ڤ Yes ڤ No Taking birth control pills? ڤ Yes ڤ No

Check (√) if you have or have had any of the following:

ڤ Anemia
ڤ Arthritis, Rheumatism
ڤ Artificial Heart Valve
ڤ Artificial Joints
ڤ Asthma
ڤ Back Problems
ڤ Blood Disease
ڤ Cancer
ڤ Chemical Dependency
ڤ Chemotherapy
ڤ Circulatory Problems
ڤ Cortisone Treatments
ڤ Cough, Persistent
ڤ Cough up blood
ڤ Diabetes
ڤ Epilepsy
ڤ Fainting
ڤ Glaucoma
ڤ Headaches
ڤ Heart Murmur
ڤ Heart Problems
ڤ Hemophilia
ڤ Hepatitis
ڤ High Blood Pressure
ڤ HIV/AIDS
ڤ Jaw Pain
ڤ Kidney Disease
ڤ Liver Disease
ڤ Mitral Valve Prolapse
ڤ Pacemaker
ڤ Radiation Treatment
ڤ Respiratory Disease
ڤ Rheumatic Fever
ڤ Scarlet Fever
ڤ Shortness of Breath
ڤ Skin Rash
ڤ Stroke
ڤ Swelling of Feet or Ankles
ڤ Thyroid problems
ڤ Tobacco Habit
ڤ Tonsillitis
ڤ Tuberculosis
ڤ Ulcer
ڤ Venereal Disease

Medications (list any that you are currently taking)_____

Allergies_____ Any other medical history?_____

AUTHORIZATION

I,_____, and/or my dependent, give authorization for Garden City Endodontics to treat me or my dependent for services stemming from a referral from my General Dentist that only an Endodontist can perform.

I understand that my insurance company has given Garden City Endodontics an estimate of its coverage for each procedure that will be performed. They have also notified Garden City Endodontics of the fee that can be charged for each procedure. Using this information, Garden City Endodontics will calculate any co-payments that need to be made, and may be able to offer me a payment plan for this balance.

I also understand that ultimately, I am responsible for the fee charged for my treatment, and that if my insurance company does not pay the maximum amount listed on my fee schedule, that I will be responsible for any remaining balance on my account.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date