

Microsurgical Endodontics

Registration

Patient name: _____ Preferred Name: _____
Address: _____ Apt#: _____ City: _____ State: ____ Zip: _____
Phone# Home: (____) - _____ Work: (____) - _____ Cell: (____) - _____
Preferred phone contact: (please circle) Home Work Cell
Social Security #: _____ - _____ - _____ Date of birth: ____ - ____ - ____
Referring dentist: _____

Complete only if information is not provided above

Person responsible for acct: _____ Relationship to Patient: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone# Home: (____) - _____ Work: (____) - _____ Cell: (____) - _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____
Name of Insurance Company: _____ Ins Co. Phone: (____) - _____
Name of Employer or Retirement Plan Offering Insurance: _____
Address: _____ City: _____ State: ____ Zip: _____
Member ID#: _____ Group ID#: _____

If coverage is through someone other than you, please provide the following:

Their Name: _____ Their Date of Birth ____ / ____ / ____
Social Security # _____ - _____ - _____ Work Phone (____) - _____

We never want you to be surprised about the cost of treatment. If you have questions about cost, please ask. You are responsible for payment at the time of treatment. Your insurance is a contract between you, your employer and your insurance company, and Microsurgical Endodontics is not a party to that contract. Therefore, your insurance coverage of our fee is the best **estimate** we are able to determine based on the information provided by you and your insurance carrier. Please understand that our calculations are strictly **ESTIMATES** and **there is no guarantee that your insurance company will reimburse us according to the estimate that they provide.** You are responsible for any portion of the fee that your insurance carrier does not pay, regardless of reason.

I hereby acknowledge that I have read and understand the above statement, authorize payment of the dental benefits otherwise payable to me directly to Microsurgical Endodontics, and authorize release of any information relating to a claim. I also acknowledge that a copy of the Privacy Policy for Microsurgical Endodontics has been made available to me.

Signature of Patient or Parent/Guardian

Date

MEDICAL/DENTAL HISTORY

Name of your Physician: _____ Date of Last Visit: _____

Please circle any of the following that you have or have had:

- | | | |
|-----------------------------|----------------------------------|---------------------------|
| Heart Trouble | Cancer | Sinus Trouble |
| Angina | Type of Cancer _____ | Environmental Allergies |
| Rheumatic Fever | Radiation Treatment | Asthma |
| Mitral Valve Prolapse | Arthritis | Substance Abuse |
| Heart Murmur | Osteoporosis | Depression/Anxiety |
| Stroke | Liver Disease-Jaundice/Hepatitis | Herpes Oral (cold sores) |
| High Blood Pressure | Kidney Disease | Venereal Diseases |
| Bleeding Disorder | Thyroid Condition | HIV Positive |
| Fainting Spells/Seizures | Reflux/GERD | AIDS |
| Clenching/Grinding of Teeth | Ulcers | Tuberculosis |
| TMJ Disorder | Crohn's/Colitis | Joint Replacement Surgery |
| Wear a Dental Night Guard | Diabetes | Major Surgery |

Please name all current medications, dosage, & reason for taking them:

Name	Dose	Reason	Name	Dose	Reason
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please list any medications you are allergic or have reacted adversely to:

Name	Reaction	Name	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke? _____

Women: Are you pregnant? _____ If Yes due date: _____

Do you have any other disease, condition, or problem not listed above? _____ Please explain _____

1. Have you had any trouble associated with previous dental treatment (dizziness, fainting or reaction to dental anesthetic)? Yes No Reaction _____
2. Are you Allergic to Latex? Yes No Reaction _____
3. Does a doctor require you to take antibiotics prior to dental treatment? Yes No Reason _____

To the best of my knowledge, the above information is correct and complete.

Patient's Signature Date

Patient's Signature (Updating Paperwork) Date

Office Use Only:

Doctor Reviewed _____

Doctor Reviewed _____