PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Date_____ Home Phone _____

Patient _____
Last Name First Name Initial

Street Address_____ City_____ State_____ Zip _____

Age_____ Birthdate_____

Employed by_____ Business Phone _____

Cell Phone_____ Email _____

Spouse/Parent Name_____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by_____ Business Phone _____

Social Security #_____ Spouse/Parent Social Security # _____

Emergency Contact_____ Phone _____

MEDICAL HISTORY

Have you ever had any of the following (check boxes that apply):

- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Mitral Valve Prolapse
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Pre-med
- ☐ Rheumatic Fever
- ☐ AIDS/HIV
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, what_____

_____

Are you taking any medication at this time?_____ If so, what _____

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions? _____

If patient is a child, what is his/her weight?_____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

_____

(OVER)

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to **Northland Endodontics** all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

MINOR/CHILD CONSENT

I, being the parent or guardian of_____ do hereby request
Name of minor/child

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

FINANCIAL AGREEMENT

I acknowledge that payment is expected at the time of service by CASH/CHECK/VISA/MASTERCARD, unless other arrangements are made. I agree that parents/ guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. A finance charge of 1.5% per month (18% annually) will be applied to all accounts not paid within 45 days of service. In the event a collection agency is necessary, I will be responsible for all reasonable collection and attorney's fees.

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature _____