



Lonestar Endodontics, P.A.

PATIENT REGISTRATION (Confidential)

(PLEASE PRINT)

NAME: _____ DATE: _____
LAST FIRST MIDDLE

ADDRESS: _____ HOME PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ BIRTHDATE: _____

EMPLOYER: _____ WORK PHONE: _____

OCCUPATION: _____ S.S.# _____ E-MAIL _____

MOBILE PHONE _____

REFERRED BY: _____

PURPOSE FOR VISIT: _____

IN CASE OF EMERGENCY NOTIFY:

1. NAME: _____ PHONE: _____

2. NAME: _____ PHONE: _____

PERSON RESPONSIBLE FOR ACCOUNT PAYMENT IF OTHER THAN PATIENT

NAME: _____ S.S.#: _____
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT: _____ HOME PHONE: _____

ADDRESS IF DIFFERENT: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY

NAME OF DENTAL INSURANCE CO: _____ PHONE: _____

SECONDARY

NAME OF DENTAL INSURANCE CO: _____ PHONE: _____

I, _____ hereby authorize the office of Lonestar Endodontics, P.A. to discuss my treatment and financial information with _____.

(your name)

(name)

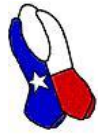
I understand that by signing this release form I am complying with HIPPA Privacy Laws. The person(s) I listed above has my permission to discuss my personal dental information. _____

(Signature)

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that the credit card given at time of treatment will be retained on file in an encrypted and secure format to be used for credits and debits to my patient account. I acknowledge that I will be notified prior to any debit or credit to my card.

X _____
Signature of patient (or parent/guardian if minor)



Lonestar Endodontic Associates

PATIENT MEDICAL HISTORY

ARE YOU IN GOOD HEALTH? _____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

IF YOU ARE UNDER THE CARE OF A PHYSICIAN, PLEASE GIVE REASON(S) FOR TREATMENT. _____

PHYSICIAN'S NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE (____) _____

ARE YOU TAKING ANY MEDICATIONS AT THIS TIME? YES ___ NO ___

IF YES, WHAT ARE THEY? _____

DIABETES LAST A1C _____ DO YOU CHECK YOUR BLOOD SUGAR REGULARLY? YES ___ NO ___

HAVE YOU EVER BEEN ADMITTED TO THE HOSPITAL? YES ___ NO ___

IF YES, FOR WHAT (INCLUDE DATES IF KNOWN). _____

HAVE YOU EVER HAD AN UNUSUAL REACTION TO AN ANESTHETIC OR DRUG? YES ___ NO ___

IF YES, EXPLAIN _____

HAVE YOU EVER HAD TROUBLE WITH PROLONGED BLEEDING AFTER SURGERY? YES ___ NO ___

ARE YOU ALLERGIC TO LATEX OR RUBBER PRODUCTS? YES ___ NO ___

ARE YOU ALLERGIC TO ANY MEDICATION OR OTHER SUBSTANCE? YES ___ NO ___

ARE YOU TAKING OR HAVE YOU PREVIOUSLY TAKEN MEDICATION FOR YES ___ NO ___

OSTEOPOROSIS SUCH AS FOSAMAX, ACTONEL OR ZOMETA?

*******PLEASE CIRCLE Yes or No*******

YES NO HEART TROUBLE, HEART ATTACK, STROKE

YES NO PACEMAKER

YES NO HYPERTENSION, HIGH BLOOD PRESSURE

YES NO PAIN IN CHEST / SHORTNESS OF BREATH

YES NO SWELLING IN ANKLES

YES NO ARTIFICIAL HEART VALVE

YES NO ARTIFICIAL JOINTS (KNEE, HIP, ETC.)

YES NO SORES THAT DO NOT HEAL IN 1 WEEK

YES NO UNUSUAL WEIGHT GAIN OR LOSS

YES NO ASTHMA, HAY FEVER

YES NO RADIATION TREATMENT

YES NO THYROID CONDITION

YES NO CHRONIC SINUS PROBLEMS

YES NO TUBERCULOSIS

YES NO SEIZURES, FAINING SPELLS, EPILEPSY

YES NO WOMEN – ARE YOU PREGNANT

YES NO HIV/AIDS

YES NO KIDNEY TROUBLE

YES NO LIVER TROUBLE

YES NO STOMACH OR DIGESTIVE DISORDERS

YES NO ULCERS

YES NO HEPATITIS

YES NO JAUNDICE

YES NO ARTHRITIS

YES NO BLOOD DISORDERS, ANEMIA

YES NO ABNORMAL BLEEDING

YES NO BLACK-OUTS

YES NO DIABETES

YES NO HYPOGLYCEMIA

YES NO EATING DISORDERS

YES NO DO YOU SMOKE

YES NO TUMORS, LESIONS, CANCER

YES NO WOMEN- DO YOU TAKE BIRTH CONTROL PILLS?

IS THERE ANY OTHER INFORMATION THAT SHOULD BE KNOWN ABOUT YOUR HEALTH OR ABOUT PREVIOUS DENTAL VISITS? _____