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Patient Registration and Health History Form

Please print only. On future visits, please be sure to update your medical history.

Patient Information

❑ Mr. ❑ Ms. ❑ Mrs. ❑ Dr. First name _____ M. I. _____ Last name _____

Sex: ❑ M ❑ F Date of birth: / / Email: _____

Street: _____

City: _____State: _____Zip: _____

Phones: Home: _____Business: _____Cell: _____

General dentist: _____Referred by: _____
(First and last name) (Please write "same" if referred by general dentist)

Other dental specialists you see (i.e., periodontist): _____

Physician: _____Phone: _____

Emergency Contact

In case of emergency contact: _____ ❑ Spouse ❑ Father ❑ Mother ❑ Other

Phones: Home: _____Business: _____Cell: _____

Reason for Visit

What is the reason for your visit today?

_____

_____

_____

_____

How long have you had this problem?

_____

What are your symptoms?

_____

_____

Medical History

Please answer the following questions to the best of your knowledge. Although endodontists primarily treat the mouth area, medical problems or medications could have a significant impact on your dental treatment. Your answers are confidential.

Y N Are you in good health? Height: _____ Weight: _____

Y N Are you under the care of a physician? Date of last physical examination: _____

Y N Have you had any illness, operation, or been hospitalized in the past five years? _____

Please circle all that apply.

Y N Prosthetic joint implant _____	Y N Emphysema	Y N Bisphosphonates: Fosamax, Acetonel, Aredia, Boniva, Zometa, and Didronel
Y N Heart valve replacement or vascular graft	Y N Parkinson's disease	Y N Arthritis/joint disease
Y N Damaged heart valves/prosthetic valve	Y N Smoking/chewing tobacco	Y N Stomach ulcers/GERD
Y N Heart attack(s)/myocardial infarction (MI)	Y N Blood transfusion	Y N Irritable bowel syndrome
Y N Irregular heart beat/tachycardia	Y N Blood disorder/anemia	Y N Contagious diseases
Y N High blood pressure	Y N Bruise easily	Y N Delay in healing
Y N Low blood pressure	Y N A history of drug abuse	Y N Anemia
Y N Chest pain/angina	Y N Eye disease/glaucoma	Y N Tumor/ growth
Y N Mitral valve prolapse/heart murmur	Y N Abnormal bleeding	Y N Breast surgery of any type
Y N Rheumatic Fever/Rheumatic Heart Disease	Y N Hepatitis/jaundice/liver disease	Y N Radiation/chemotherapy/cancer
Y N Cardiac pacemaker	Y N HIV/AIDS/STD	Y N Are you on a diet
Y N Heart surgery/bypass surgery	Y N Infectious mononucleosis	Y N Immune system problems
Y N Stroke/Transient Ischemic Attack (TIA)	Y N Gallbladder trouble	Y N Malignant hyperthermia
Y N Convulsions/epilepsy	Y N Fainting spells	Y N History of alcohol abuse
Y N Bronchitis/chronic cough	Y N Thyroid trouble	Y N Chronic fatigue
Y N Asthma	Y N Diabetes	Y N Mental health problems
Y N COPD	Y N Swollen ankles/joint disease	
Y N Respiratory problems	Y N Low blood sugar	Other _____
Y N Tuberculosis	Y N Kidney trouble	
	Y N Are you on dialysis	

Medications

Are you taking any of the following medications (please circle)?

Blood thinner: Coumadin (Warfarin)	Alpha-adrenergic blockers, phenoxybenzamine, prazosin
Ephedra, yohimbe *herbals*	Levodopa, thyroid hormones: levothyroxine, liothyronine
Antipsychotic, haloperidol, thioridazine	Beta-adrenergic blockers, nonselective, *antiarrhythmic agent, Class II*, dorzolamide/timolol, levobunolol, metipranolol, nadolol, nadolol/bendroflumethiazide, propranolol, sotalol, timolol
Catechol-O-methyltransferase inhibitor	CNS stimulants: amphetamine, methylphenidate, ergot derivatives: dihydroergotamine, methysergide
	Digitalis: digoxin, digitoxin
Cocaine	Methyldopa, adrenergic neuronal blocking drugs: guanadrel, guanethidine, reserpine
MAO *antidepressant*	Tricyclic *antidepressants* amitriptyline, amoxapine, clomipramine, desipramine, doxepin, imipramine, nortriptyline, protriptyline, trimipramine Maprotiline

Please list all medications you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____

Please circle all that apply.

Allergies

Y N Penicillin, Amoxicillin, Augmentin	Y N Valium or other tranquilizers
Y N Aspirin, Advil, Motrin, ibuprofen	Y N Local anesthetic (novocaine, adrenalin)
Y N Sulfa/sulfites	Y N Codeine or other narcotics
Y N Other antibiotics	Y N Latex
Other_____	Other_____

Women

Y N Are you pregnant? If yes, estimated delivery date: _____
Y N Is there a possibility of pregnancy?
Y N Are you nursing?
Y N Are you taking birth control pills? (Antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control if antibiotics are prescribed.)

All Patients

Y N Have you been told by your physician to take antibiotics prior to dental treatment?
Y N Is there any health condition about which the doctor should know?
Y N Do you wish to speak to the doctor privately about anything?

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my endodontist, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I understand that I am responsible for notifying my endodontist of any medical changes upon each visit.

_____

Patient Signature (Parent or Guardian if minor) **Print Full Name** **Date**

Authorization

I authorize my endodontist and his/her staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. If medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

_____

Patient Signature (Parent or Guardian if minor) **Print Full Name** **Date**

Doctor: X _____ **Witness: X** _____

Acknowledgement of Receipt of Notice of Privacy Practice

Bethesda Chevy Chase Root Canal Specialists, LLC **Notice of Privacy Practices** provides information about how our practice might use and disclose protected health information about you and is compliant with requirements of the Health Insurance Portability Act of 1996 (HIPAA). Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, a notice will be prominently posted in our offices. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Insurance carrier benefits be made on my behalf to Bethesda Chevy Chase Root Canal Specialists, LLC for any services furnished to me by that provider. I authorize any holder of medical information about me to release to all Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier Agreements.

_____

Patient Signature (Parent or Guardian if minor) **Print Full Name** **Date**

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPAA Policy Officer for the practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filling a complaint.