Contact Information:
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REGISTRATION FORM

Charles H. Stuart DDS David T Holden DMD

(Please Print)

Today's date: **Referring Dentist:**

PATIENT INFORMATION

Patient's last name: **First:** **Middle:**			❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	
Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**		**Birth date:** / /	**Age:** **Sex:** ❑ M ❑ F
Street address:		**Social Security no.:**		**Home phone no.:** ( )
P.O. box:	**City:**		**State:**	**ZIP Code:**
Occupation:	**Employer:**			**Employer phone no.:** ( )

Other family members seen here:

DENTAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	**Birth date:** / /	**Address (if different):**	**Home phone no.:** ( )
Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:** ( )

Is this patient covered by insurance? ❑ Yes ❑ No		**Name of Primary Insurance:**		
Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:** / /	**Group no.:**	**Policy no.:**
Patient's relationship to subscriber: ❑ Self ❑ Spouse		❑ Child	❑ Other	
Name of secondary insurance (if applicable):		**Subscriber's name:**		
Patient's relationship to subscriber: ❑ Self ❑ Spouse		❑ Child	❑ Other	**Group no:** **Policy no:**

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone no.:** ( )	**Work phone no.:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize WestSide Endodontics **or insurance company to release any information required to process my claims.**

***Patient/Guardian signature*_____** ***Date*_____**

Patient Name: _____ Date: _____

PLEASE CHECK YES OR NO TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS OR TREATMENTS:

Actonel	☐ Yes ☐ No	Diabetes Type I	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Alcohol Dependency	☐ Yes ☐ No	Diabetes Type II	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Allergies (Seasonal)	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Prolonged Bleeding	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or Dizziness	☐ Yes ☐ No	Radiation treatment	☐ Yes ☐ No
Are you Pregnant or Nursing	☐ Yes ☐ No	Fosamax	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Are you using oral contraceptives	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Arthritis/Rheumatism	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis Type_____	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Bisphosphonate	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	Stomach Ulcer	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Hives or Skin Rash	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Boniva	☐ Yes ☐ No	Hormone Replacement Therapy	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Swollen Glands	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemo-Therapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Other_____	
Cortisone/Steroid Treatments	☐ Yes ☐ No	Nervous Disorder	☐ Yes ☐ No		

ARE YOU ALLERGIC OR HAVE REACTED ADVERSELY TO:

Nova Caine ☐ Codeine ☐ Penicillin ☐ Aspirin ☐ Adhesives or Tape
☐ Latex ☐ Iodine ☐ Barbiturates ☐ Sulfa Drugs ☐ Other _____

Do you take antibiotic therapy for a medical condition before dental work? _____

Did or Do you smoke ☐ Yes ☐ No How many Packs/day _____ How many years_____ **Quit Date: ___/_____/_____**

LIST MEDICATION AND HERBAL REMEDIES YOU ARE TAKING ON A REGULAR BASIS:

_____ _____ _____
_____ _____ _____
_____ _____ _____

List Hospitalizations, Serious Illness and Surgeries for the past 5 years (list date and procedure:

_____

_____

Physcians_____**Physcian's Phone #**_____
Pharmacy Name_____ **Pharmacy Phone #**_____

Consent for Assignment of Benefits and treatment: I certify that me or my dependents have insurance coverage with the above names carrier and I assign directly to WestSide Endodontics all insurance 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 authorize the use of my signature on all insurance submissions. The above names practice, its agents, and assignees may use my health care information and may disclose such information to above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I grant permission for the above names' endodontist, or endodontic associates and their assistants to render care in the diagnosis and/ or treatment of my dental conditions and release related information to my 3rd party payers, physician and/or emergency medical personal and as required by law.

_____ _____
Signature of Patient, Parent, Legal Guardian or Personal Representative *Printed Name of Patient, Parent, Legal Guardian or Personal Representative*

Reviewed by Dr._____ **Date:** _____ **Assistant:** _____