MID-COUNTY ENDODONTIC GROUP, P.A.
60 W. RIDGEWOOD AVE. RIDGEWOOD NJ 07450 201.652.3311
250 KINDERKAMACK RD. WESTWOOD NJ 07675 201.666.4546

PATIENT REGISTRATION

Date:_____

Patient's Name:_____ Title: _____

Parent's name (if patient is a minor):_____

Date of Birth: _____ SS# _____ Marital status: _____ Sex: _____

Home Address:_____City_____State_____Zip_____

Home Phone: _____ Cellular Phone: _____

Employer : _____ Work Phone: _____

Person responsible for account:_____

General Dentist:_____ Referred by:_____

Have you been a patient with us before? _____ When? _____

MEDICAL HISTORY

Are you currently under the care of a physician? ☐Yes ☐No For what condition? _____

If yes, name and phone # of your physician:_____

Do you take an aspirin a day? ☐Yes ☐No Do you take coumadin? ☐Yes ☐No

Are you currently taking or have you previously taken Bisphosphonate medications such as:
Fosamax, Actonel or Zometa within the past 12 months? ☐Yes ☐No

Are you currently taking immune suppressive medications such as Corticosteroids? ☐Yes ☐No

Have you had or do you currently have? Please circle

*Congenital heart defects	Cancer	Thyroid disease
*Damaged heart valves	Rheumatic fever	Kidney disease
*Repaired heart valves	Mitral valve prolapse	Bleeding disorders
*Prosthetic heart valves	Heart murmur	Hepatitis/liver disease
*Heart attack/surgery w/in 6 months	Hypertension/High blood pressure	HIV/AIDS
*Prosthetic joints w/in 2 years	Angina	Diabetes
*Radiation therapy to Head/Neck w/in 12 months	Seizures	Stomach ulcers

*****You must be pre-medicated with antibiotic prior to your dental appointment. For consultations, no need for pre-medication.

Please list all **medications** you are currently taking:

_____

_____

_____

(Please continue on opposite side)

Have you had any **allergic** reactions to the following? Please circle

Local anesthetics (eg: "novocaine")	Sedatives
Epinephrine	Iodine
Penicillin or other antibiotics	Sulfa drugs
Latex	Other _____
Aspirin or Ibuprofen	

Do you smoke? ☐Yes ☐No

Do you have any history of substance abuse? ☐Yes ☐No

Is there any other medical/dental condition the treating doctor should know?

If yes, please explain: _____

Women:

1. Are you pregnant? ☐Yes ☐No
2. Are you nursing? ☐Yes ☐No
3. Are you taking birth control? ☐Yes ☐No

I certify that the information on these pages are correct and accurate. I also certify that I am the patient (or authorized agent of the patient) authorized to furnish all information requested.

Patient / (or Guardian) Signature: _____

Dental Insurance Information

Insurance company name and address: _____

Subscriber's name : _____ SS# _____ DOB:_____

Relation to patient: _____

Subscriber address: _____

Subscriber's employer name and address: _____

Group or Policy # : _____

Secondary insurance company name and address: _____

Subscriber's name : _____ SS# _____ DOB:_____

Relation to patient: _____

Subscriber's employer name and address: _____

Group or Policy # : _____

RETURN VISIT UPDATE

(For patients who have not been seen at our office for over a year)

Date _____

Have there been any changes in your medical history since your last visit? ☐Yes ☐No

Comments _____

_____

Signature: _____