IVY ENDODONTIC GROUP
PRACTICE LIMITED TO ENDODONTICS
Serving Orange County Since 1989

Dental Registration and History

Date _____

Patient Information

Please print

Name _____
Last Name *First Name* *Initial*

Home Address _____
Street *City* *State* *ZIP*

Birthdate ___/___/___ Social Security No. ___-___-___ Driver's License/ID No. _____

Sex ❑ *M* ❑ *F* Status ❑ *Married* ❑ *Single* ❑ *Widowed* ❑ *Separated* ❑ *Divorced* ❑ *Minor* ❑ *Other* _____

Employer/School _____ Occupation _____

Employer/School Address _____
Street *City* *State* *ZIP*

Phone and Contact Information

Home _____ Mobile _____ Work _____

e-mail _____ Best time and place to reach you? _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home _____ Mobile _____ Work _____

Dental Insurance

Primary Insurance Company _____ Phone _____

Member Name _____ D.O.B. ___/___/___ Relation _____

Member ID# _____ SS# ___-___-___ Group/Plan/Policy# _____

Member's Employer _____

Employer Address _____ Phone _____
Street *City* *State* *ZIP*

Secondary Insurance Company *(if applicable)* _____ Phone _____

Member Name _____ D.O.B. ___/___/___ Relation _____

Member ID# _____ SS# ___-___-___ Group/Plan/Policy# _____

Member's Employer _____

Employer Address _____ Phone _____
Street *City* *State* *ZIP*

Dental History

Reason for today's visit? _____

Your present Family Dentist: _____ Phone _____

Are you currently in pain? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

Have you ever had periodontal *(gum)* disease? ❑ Yes ❑ No

Do you have loose teeth or broken fillings? ❑ Yes ❑ No

Are your teeth sensitive to: ❑ Cold ❑ Heat ❑ Sweets ❑ Biting ❑ Other _____

How often do you brush and floss? _____

Health History

Physician's name _____ Phone _____ Date of Last Visit _____

AIDS/HIV	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Respiratory Disease	❑ Yes ❑ No
Artificial Heart Valves	❑ Yes ❑ No	Fainting *or* Dizziness	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Artificial Joints	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No
Back Problems	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Bleeding abnormally with extractions	❑ Yes ❑ No	Heart Problem	❑ Yes ❑ No	Skin Rash	❑ Yes ❑ No
		Hepatitis, *Type* ____	❑ Yes ❑ No	Special Diet	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Swelling of Feet/Ankles	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No	Swollen Neck Glands	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Jaw Pain	❑ Yes ❑ No	Thyroid Problem	❑ Yes ❑ No
Cholesterol	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Circulatory Problems	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Congen. Heart Lesions	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Ulcer	❑ Yes ❑ No
Cortisone Treatment	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Cough (Persistent)	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No		

Women:
Are you pregnant? ❑ Yes ❑ No Due Date: _____ Are you nursing? ❑ Yes ❑ No

Medications

List any medications you are currently taking and correlating diagnosis: _____

_____

Are you taking: ❑ Fosamax ❑ Coumadin

Pharmacy name: _____ Phone _____

Allergies

❑ Aspirin	❑ Latex	❑ Other _____
❑ Barbiturates *(sleeping pills)*	❑ Local Anesthetic	_____
❑ Codeine	❑ Penicillin	_____
❑ Iodine	❑ Sulfa	_____

Assignment and Release

I hereby authorize payment directly to **Ivy Endodontic Group** for all insurance benefits.

I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize **Ivy Endodontic Group** or any provider or supplier of services in this office to release the information required to secure the payments of benefits.

I authorize the use of this signature on all insurance submissions.

Patient, Parent or Responsible Party _____ Relationship to Patient _____
Please Print

Patient, Parent or Responsible Party _____ Date ___/___/___
Signature

For Office Use:

Reviewed by Dr. _____ Date ___/___/___ Witness _____ Date ___/___/___
Signature *Signature*