Patient Registration

PATIENT INFORMATION							
First Name		Middle Initial		Last Name			
Nickname		Gender	❑ Male ❑ Female ❑ Other	Birth Date		Age	
E-mail							
Address		City		State		ZIP Code	
Phone		❑ Home ❑ Cell					

WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE?	
❑ Referring Doctor ❑ Current Patient ❑ Internet ❑ Insurance ❑ Other: ____________________	
Referral Name	

RESPONSIBLE PARTY (if self is selected, please skip to the next section)							
❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other: ____________________							
First Name		Last Name					
Birth Date		Age		Telephone			
Address		City		State		ZIP Code	

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY						SECONDARY DENTAL INSURANCE COMPANY					
Primary Policy Holder	First	Last				Primary Policy Holder	First	Last			
Birth Date		Gender	❑ Male ❑ Female			Birth Date		Gender	❑ Male ❑ Female		
Relationship to Patient						Relationship to Patient					
Insurance Co. Name						Insurance Co. Name					
Address						Address					
City		State		ZIP Code		City		State		ZIP Code	
Telephone						Telephone					
Insurance ID #						Insurance ID #					
Group #						Group #					

EMERGENCY CONTACT			
First Name		Last Name	
Telephone		Relationship to Patient	

Rhode Island Endodontics

Usman Fazli, DMD

Diplomate, American Board of Endodontics

Fellow of Royal College of Dentists Canada

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HEALTH HISTORY

Height		Weight	

Are you under the care of a physician? If yes, please complete the line below.	❑ Yes ❑ No

Date of Last Visit		Physician Name		Physician Phone	
Preferred Pharmacy		Pharmacy Location		Pharmacy Phone	

Have you had any recent or scheduled surgeries?	❑ Yes ❑ No
If yes, please describe	
Do you smoke or use tobacco?	❑ Yes ❑ No
Are you taking Bisphosphonates?	❑ Yes ❑ No

How long?		❑ Oral ❑ Injectable ❑ IV	Last treatment date?	

FOR WOMEN ONLY

Are you pregnant?	❑ Yes ❑ No	If yes, number of weeks	
Are you nursing?	❑ Yes ❑ No	Are you taking birth control pills?	❑ Yes ❑ No

WARNING: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control.

Do you have, or have had, any of the following?

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding			Emphysema			Mitral Valve Prolapse		
Alcohol Abuse			Epilepsy			Osteoporosis		
Allergies			Fainting Spells			Pace Maker		
Anemia			Fever Blisters			Psychiatric Problems		
Angina Pectoris			Glaucoma			Radiation Therapy		
Artificial Bones			HIV+ AIDS			Rheumatic Fever		
Artificial Heart Valve			Heart Attack			Seizures		
Artificial Joints			Heart Surgery			Shingles		
Asthma			Hemophilia			Sickle Cell Disease		
Blood Transfusion			Hepatitis			Stroke		
Cancer - Chemotherapy			High Blood Pressure			Thyroid Problems		
Congenital Heart Defect			High Cholesterol			Tuberculosis		
Diabetes			Kidney Problems			Ulcers		
Difficulty Breathing			Liver Disease			Yellow Jaundice		
Drug Abuse			Low Blood Pressure					

Is there any disease, condition, or problem that you think our office should know about that is not listed above? If yes, please list below.

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MEDICATIONS

Please list all medications, over the counter and herbal supplements, that you are currently taking (include medication name, dosage and frequency):

ALLERGIES/REACTIONS

Are you allergic to, or had a reaction to any of the following?

	Yes	No		Yes	No
Aspirin			Codeine		
Dental Anesthetics			Erythromycin		
Jewelry			Latex		
Metals			Penicillin		
Tetracycline			Other		

Please list any allergy/reaction that you have or have had that is not listed above.

ADDITIONAL NOTES/COMMENTS:

FORM COMPLETION

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

There may be an increased risk of COVID -19 exposures at this time. I also understand it is possible to be exposed to COVID during any appointment that includes close human contact. I understand I may have been exposed to COVID at any time prior to my treatment at this office.

Signature of	❑ Patient ❑ Legal Guardian	❑ Parent ❑ Agent Under Durable Power of Attorney
Printed Name	*First Name*	*Last Name*

Signature of Patient, Parent or Guardian		**Date**	