ENDODONTIX
DENTAL GROUP, P.A.

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305-447-4000
www.endodontix.com

Patient Registration

Check title: Mr. ❑ Ms. ❑ Mrs. ❑ Dr. ❑ Other:_____

First name:_____ Middle initial:_____ Last name:_____

Sex (check): Female ❑ Male ❑ Date of Birth:_____ Social Security #:_____

Home phone:_____ Business phone:_____ Ext._____

Mobile phone:_____ Email:_____

Street:_____

City:_____ State:_____ Zip:_____

Discomfort (check): None ❑ Slight ❑ Moderate ❑ Severe ❑

General Dentist:_____ Referred By:_____
(First Name Last name) *(First Name Last name)*
(Please write "same" if referred by general dentist)

Physician:_____ Phone:_____
(First Name Last name)

In case of emergency contact:_____ Relationship:_____ Phone:_____

Health History

Please fill out the following health history to the best of your knowledge. All patient information is confidential. Although endodontists primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care, that you will be receiving. Your answers are for our records only and will be considered confidential.

Do you have any health problems? **Yes** ❑ **No** ❑

Height : _____

Weight: _____

Have there been any changes in your general health in the past year? **Yes** ❑ **No** ❑

Are you under the care of a physician? **Yes** ❑ **No** ❑

If so, for what are you being treated?_____

Date of last medical examination? _____

Have you had any illness, operation or been hospitalized in the past five years? **Yes** ❑ **No** ❑

Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? **Yes** ❑ **No** ❑

If so describe where: _____

Do you have a prosthetic joint? **Yes** ❑ **No** ❑

If so, describe where:_____

Do you have a heart valve replacement or vascular graft? **Yes** ❑ **No** ❑

If so, describe where: _____