Registration Form

CENTRAL PENN ENDODONTICS

Date _____
Have you been a patient of ours before? _____

Name _____ Phone – Home _____
Address _____ Work _____
City _____ State ____ Zip _____ Cell _____
Birth date _____ Sex _____ Preferred daytime phone: ☐Home ☐Cell ☐Work

If patient is a minor, name of person responsible for account _____
Address _____
Phone _____ *SS#* _____ *Birth date* _____

Social Security # _____
Patient's Occupation _____ Employed by _____
Address _____
Name of Spouse/Parent _____ Phone _____
Occupation _____ Employer _____

Medical Questionnaire

Check if you've ever had the following medical conditions:

- ☐ Currently Pregnancy / Nursing
- ☐ Serious Illness
- ☐ Major Operation
- ☐ Injury to Jaw or Face
- ☐ High or Low Blood Pressure
- ☐ Bleeding Problems
- ☐ Sinus troubles
- ☐ Heart Disease / Heart Attack
- ☐ Stroke
- ☐ Asthma
- ☐ Diabetes
- ☐ Kidney Troubles
- ☐ Hepatitis / Liver Problems
- ☐ Tuberculosis
- ☐ Thyroid / Hormonal Problems
- ☐ Ulcers / Stomach Problems
- ☐ Infectious Disease
- ☐ Knee / Hip Replacement

Please list your medications:

Please list any other medical conditions not noted above: _____

Are you allergic to: ☐ latex ☐ penicillin ☐ aspirin ☐ other – Please list: _____

Do you take antibiotics before dental treatment due to joint replacemen☐, heart conditio☐, or other☐

Are there any other concerns we should know about? _____

Thank you for your assistance!

Signature _____ *Date* _____