WELCOME TO COASTAL ENDODONTICS

e want to welcome you to our office and thank you for entrusting us with your endodontic needs and care. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, appointments, or fees, please feel free to ask.

REGISTRATION

PLEASE PRINT CLEARLY

Date _____

Patient's Name (Last, First, MI) _____ ○ ○ ○ ○ **Mr. / Mrs. / Ms. / Dr.**

Address _____**City/State**_____**Zip Code**_____

Home Ph# _____**Work Ph#** _____**Cell Ph#**_____ ○○○ **Prefer: H/W/C**

Nickname _____**Patient S.S. #** _____-_____-_____ **Date of Birth** _____

Employer _____ **Email** _____

Bus. Address _____

_____ **Physician** _____ **Office #** _____

If patient is a minor- Guardian name _____ **DOB** _____ **SS#** _____

Whom may we contact in case of an emergency? _____**Phone** _____

DENTAL HISTORY

Referred Today By _____ **Reason** _____

General Dentist _____ **Last Seen by him/her**_____

Have you had previous root canal therapy? ○**YES** ○**NO If yes, when?**_____

Are you having any pain? ○**YES** ○**NO If yes, please grade on scale of 1-5**_____ **For how long?** _____
(1being dull pain- 5 being severe)

Circle which of the following sensitivities that apply to you today: ○ **HOT** / ○ **COLD** / ○ **BITING PAIN** / ○ **THROBBING**

RECEIPT OF ACKNOWLEDGMENT OF AUTHORIZATION

Please sign below to indicate that you are aware that the Notice of Privacy Practice Act information is accessible to you upon request.

Signature _____ **Date** _____

***Please indicate below whom, other than your General Dentist/ Referring Doctor we can speak with in reference to your medical treatment, insurance questions, account information, and general messages (ex. Appointments, etc…):**

***I AUTHORIZE DETAILED MESSAGES TO BE LEFT ON MY: HOME# / WORK # / CELLULAR PHONE #**
(PLEASE CIRCLE ALL THAT APPLY)

_____ _____/_____
Name **Relationship** **Tel. #**

_____ _____/_____
Name **Relationship** **Tel. #**

COASTAL ENDODONTICS

PATIENT HEALTH HISTORY

Date:_____

Name:_____

- ☐ Pregnant
- ☐ Fatigue
- ☐ Swelling/Edema
- ☐ Anemia/Bleeding
- ☐ Immunocomprimised
- ☐ Herpes
- ☐ Venereal Disease
- ☐ Infectious Disease
- ☐ High Blood Pressure
- ☐ Hypertension/Circula
- ☐ Heart Disease
- ☐ Heart Murmur/Defect
- ☐ Pacemaker
- ☐ Heart Attack/ Stroke
- ☐ Irregular Heart Beat
- ☐ Angina
- ☐ High Cholesterol
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Thyroid
- ☐ Cancer

- ☐ Radiation/Chemo
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Joint Replacement
- ☐ Prosthetic Implant
- ☐ Any Transplant
- ☐ Smoke
- ☐ Shortness of Breath
- ☐ Hypoglycemia
- ☐ Ulcers/Digestive
- ☐ Migraines/Headache
- ☐ Epilepsy/Fainting
- ☐ Glaucoma/Visual
- ☐ Mental/ Neural
- ☐ Depression
- ☐ Alcoholism/Addiction
- ☐ TMJ
- ☐ Asthma
- ☐ OTHER
- ☐
- ☐

Allergies

- ☐ No Medical Allergies
- ☐ Antibiotics
- ☐ Penicillin
- ☐ Tylenol
- ☐ Codeine
- ☐ Narcotics
- ☐ Local Anesth
- ☐ Latex
- ☐ Valium/Tranquil.
- ☐ Nitrous Oxide
- ☐ Foods
- ☐ Bleach
- ☐ Iodine/Seafood
- ☐ Sulfa
- ☐ Aspirin
- ☐ Seasonal
- ☐ OTHER
- ☐
- ☐
- ☐

Medications

- ☐ No Medications
- ☐ Antibiotic
- ☐ Pain Medicine
- ☐ Heart Medicine
- ☐ Aspirin
- ☐ Cortisone/Steriods
- ☐ Blood Thinner
- ☐ Blood Pressure
- ☐ Hormone
- ☐ Thyroid
- ☐ Birth Control Pills
- ☐ Insulin
- ☐ Ulcer/Nexium
- ☐ Bone Related
- ☐ Antidepressants
- ☐ Relaxants
- ☐ Cholesterol
- ☐ Vitamins
- ☐ Sleep Aids
- ☐ OTHER

****Please list <u>ALL</u> medications****

_____

_____

_____

The information above is correct.

_____ _____

Name Date

PHARMACY_____ PHARMACY PHONE #_____

I confirm that I am NOT presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat
- _____ (initial)