EXPERT ENDODONTICS

The Root Canal Specialists

New Patient Registration

"To help us provide you with the best care, please fill out the medical history form below to the best of your ability. Don't hesitate to ask our front desk team if you need any clarification or have any questions."

Patient Name:_____ DOB:_____
SSN:_____
Phone: Primary: _____Secondary: _____E-mail:
_____
Mailing
Address:_____
_____
Street City State Zip
If Patient is a Minor, Who is Accompanying the Patient Today? _____ Legal Guardian ☐ YES ☐NO
Employer: _____ Occupation: _____ How long?
_____
Employer's Address:
_____
Street City State Zip
Whom may we thank for referring
you?_____
Who is your General Dentist?
_____
Emergency Contact Name: _____Contact Phone:
_____
Are there any special dental considerations that we should be aware of? ☐YES ☐NO
Please Explain:
_____
_____

Dental Insurance Information

Insurance Company Name: _____ Phone Number:
_____
Subscriber's Name: _____ Relationship to Patient:
_____
Subscriber's DOB: _____ Subscriber's SSN:
_____
Subscriber's Employer: _____ Employment Date _____ Work Phone:
_____
Subscribers ID#:_____Group #:
_____

Secondary Dental Insurance Information (If Applicable)

Insurance Company Name: _____ Phone Number:
_____

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Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's DOB: _____ Subscriber's SSN: _____

Subscriber's Employer: _____ Employment Date _____ Work Phone: _____

Subscribers ID#:_____Group #: _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ Relationship to Patient: _____

Address:_____

_____

Street City State Zip

Home Phone: _____Alternate Phone: _____Email: _____

DOB: _____SSN#_____ Driver's license #_____

Employer: _____Work Phone: _____

PATIENT/LEGAL GUARDIAN SIGNATURE: _____DATE: _____

PATIENT MEDICAL HISTORY

Patients Name: _____Today's Date: _____

Height: _____Weight: _____ Gender: _____ If Patient a Minor, Who is Accompanying the Patient Today? _____

Name of Physician: _____Phone: _____

Date of Last Visit: _____Reason for Last Visit: _____

For Women:

Date of last menstrual cycle: _____ Are you pregnant? ☐NO ☐YES, How far along? _____

Are you nursing? ☐YES ☐ NO On birth control? ☐YES ☐NO Is there any chance you may be pregnant? ☐ YES ☐NO

Have you ever had any of the following diseases or medical problems? (please check □)

Medical Condition	Y	N	Medical Condition	Y	N	Medical Condition	Y	N
AIDS			Drug Abuse			Knee Replacement		
Alcohol Abuse			Emphysema			Joint Replacement		
Anemia			Epilepsy			Liver Disease		
Arthritis			Fainting			Mitral Valve Prolapse		
Asthma			Heart Attack			Pacemaker		
Bleeding Problems			Heart Murmur			Radiation Treatment		
Blood Transfusion			Heart Surgery			Rheumatic Fever		
Breathing Problems			Heart Valve Replacement			Seizures		
Cancer/Chemotherapy			Hemophilia			Sinus Problems		
Colitis			Hepatitis			Steroid Therapy		
Congenital Heart Defect			High Blood Pressure			Subacute Bact Endocarditis		
Defibrillator			Hip Replacement			Thyroid Treatment		
Diabetes			HIV			Ulcers		
Dizzy Spells			Kidney Problems			Other? Please specify Below		

Other Medical Conditions:

_____

Have you ever taken bisphosphonates (used to treat osteoporosis & certain types of cancer). ☐YES ☐NO

Allergies (please check □)						Current Medications		
	Y	N		Y	N	Name of Prescription	Dose	Condition
Penicillin			Latex					
Antibiotics			Local Anesthetic					
Aspirin			Bleach					
Tylenol			Ibuprofen					
Codeine			Nitirle					
Narcotics			EDTA					
Sulfa/Sulfides			Valium/Tranquil					
Other Allergies? Please Specify:_____ _____								

Surgical History:

Type: _____ Date: _____ Any Complications? _____

Type: _____ Date: _____ Any Complications? _____

Type: _____ Date: _____ Any Complications? _____

Statement of Accuracy: I certify that the information provided in this health history is accurate and complete to the best of my recollection. I acknowledge the importance of an honest health history for the purpose of receiving optimal medical care.

Record of Visit:

1st Visit: Patient Signature: _____Date: _____

Doctor Signature: _____ Date: _____

2nd Visit: Patient Signature: _____ Date: _____

Doctor Signature: _____Date: _____

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ACKNOWLEDGMENT OF RECEIPT

Notice of Privacy Practices — Effective Feb 16, 2026

Summary of Your Key Rights

- **Inspect & copy** your medical records (paper or electronic).
- **Request restrictions.** We must restrict disclosure to your health plan if you pay in full out of pocket at the time of service.
- **Confidential communications** via your preferred phone number or address.
- **Request amendment** of inaccurate or incomplete records (response within 60 days).
- **Revoke an authorization** (in writing) for non-routine uses such as research or marketing. Routine uses for treatment, billing, and operations are permitted by law and cannot be revoked.
- **Breach notification** within 60 days if your unsecured PHI is compromised.
- **File a complaint** with our Privacy Officer, HHS OCR (1-877-696-6775), or TX AG (1-800-621-0508). No retaliation.

Patient / Authorized Representative

Patient Full Name (Print)	Signature	Date

If signed by a parent, guardian, or authorized representative:

Representative Full Name (Print)	Relationship to Patient	Signature	Date

This form should be retained in the patient's file. — Expert Endodontics