

### Patient Registration

(If patient is a minor, please fill in the Parent's appropriate information.)

Your name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Social Security Number \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Cell Number \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

General Dentist Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

How were you referred? \_\_\_\_\_

### DENTAL INSURANCE

Name of Person Responsible for this Account? \_\_\_\_\_

Policy Holder \_\_\_\_\_

Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_

Subscriber ID# \_\_\_\_\_

Social Security# \_\_\_\_\_

Group # \_\_\_\_\_

Employer \_\_\_\_\_

## Dental History

Do you feel discomfort/pain when the tooth/teeth in question come in contact with:

Hot foods or liquids (soup, coffee, etc)? Yes  No

Cold foods or liquids (ice cream, cold water, etc)? Yes  No

Sweet or sour food (candy, oranges, fruit, etc)? Yes  No

When you bite down or chew? Yes  No

Do any of the above symptoms linger for more than a minute or so? Yes  No

Do symptoms wake you up from sleep? Yes  No

Comments: \_\_\_\_\_

## Informed Consent

We shall try to advise you as to the expected number of appointments necessary, the time needed for each appointment, what you may expect from the treatment, and the fee. It is understood that endodontic treatment is a procedure to retain a tooth which may otherwise require extraction. Although this treatment has a very high degree of clinical success, it is still a biological procedure so it cannot be guaranteed. Occasionally a tooth which has had endodontic treatment may require retreatment, surgery, or even extraction. Even with the best treatment approximately 5% of endodontically treated teeth may eventually require extraction.

When your treatment is completed, your tooth will need a final restoration (filling or crown). Our fee does not include this service. Your referring dentist will render this service which is equally important for the preservation of your tooth. The restoration should be placed a few weeks after treatment is complete. We will send a report of your treatment to your dentist.

**DENTAL INSURANCE:** As a convenience to you, our office will fill out the necessary forms and submit them to your insurance company. Most insurance companies provide coverage from 50% to 80%. Your coverage may be less depending upon remaining coverage, deductible, procedures not covered by insurance but are billable to you and other items. We require a minimum of 30% to 50% of the fee at the time of treatment. If your insurance payment is more or less, your account will be adjusted accordingly.

If you do not have dental insurance or we are not a participant, your entire fee is due at the time of your treatment.

I hereby authorize Dr. Joseph A Herbst to bill and receive payment directly from my dental insurance.

I understand and agree that I am completely responsible for the entire account despite the fact that I may have insurance coverage. If it becomes necessary to send my account for collections, I understand and agree that I will pay all reasonable fees related to collections including but not limited to collection agent fees, collection processing, lawyer's fees, court costs, and the costs of a private process server to the amount owed.

After 30 days, any unpaid balance would be subject to interest at the rate of 1.5% monthly (\$5.00 minimum).

A \$100.00 fee will be charged for broken appointments unless a 48 hour notification has been given.

There is a \$35.00 fee for returned checks or stop payment checks.

The below signature also verifies patient receipt of the Notice of Privacy Practices.

I give my permission to discuss my billing and financial information with my \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

(Guardian Signature If Patient is a Minor)

If you have any questions regarding your treatment or fees, we will be happy to discuss them with you. Should you have any concerns between visits or after completion of your treatment, please do not hesitate to call.



Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:	Date:
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**HEALTH HISTORY FORM**

Name: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_  
LAST FIRST MIDDLE  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
P.O. BOX or Mailing Address  
 Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M  F   
 SS#: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person?  
NAME RELATIONSHIP

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

**DENTAL INFORMATION**

	Yes	No	Don't Know	
Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How would you describe your current dental problem?
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you wear removable dental appliances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays:
Have you had a serious/difficult problem associated with any previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, explain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?
				_____
				How do you feel about the appearance of your teeth?
				_____

**MEDICAL INFORMATION**

	Yes	No	Don't Know	
<b>If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.</b>				
Have you had any of the following diseases or problems?				Are you taking or have you recently taken any medicine(s) including non-prescription medicine?
Active Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what medicine(s) are you taking?
Cough that produces blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prescribed: _____
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Over the counter: _____
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vitamins, natural or herbal preparations and/or diet supplements: _____
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?
If yes, what is/are the condition(s) being treated?				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Date of last physical examination: _____				Do you drink alcoholic beverages?
Physician: _____				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<small>NAME PHONE</small>				If yes, how much alcohol did you drink in the last 24 hours?
<small>ADDRESS CITY/STATE ZIP</small>				_____
<small>NAME PHONE</small>				In the past week?
<small>ADDRESS CITY/STATE ZIP</small>				_____
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you alcohol and/or drug dependent?
If yes, what was the illness or problem?				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
_____				If yes, have you received treatment? (circle one) Yes / No
_____				_____
_____				Do you use drugs or other substances for recreational purposes?
_____				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
_____				If yes, please list:
				Frequency of use (daily, weekly, etc.): _____
				Number of years of recreational drug use: _____
				Do you use tobacco (smoking, snuff, chew)?
				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
				If yes, how interested are you in stopping?
				(circle one) Very / Somewhat / Not interested
				Do you wear contact lenses?
				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

PLEASE COMPLETE BOTH SIDES

	Yes	No	Don't Know
Are you allergic to or have you had a reaction to?			
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metals (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To yes responses, specify type of reaction. _____			
_____			
_____			

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when was this operation done? _____			
If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?			
_____			
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what antibiotic and dose? _____			
Name of physician or dentist*: _____			
Phone: _____			

WOMEN ONLY			
	Yes	No	Don't Know
Are you or could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking birth control pills or hormonal replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion. If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Angina			
___ Arteriosclerosis			
___ Artificial heart valves			
___ Congenital heart defects			
___ Congestive heart failure			
___ Coronary artery disease			
___ Damaged heart valves			
___ Heart attack			
___ Heart murmur			
___ High blood pressure			
___ Low blood pressure			
___ Mitral valve prolapse			
___ Pacemaker			
___ Rheumatic heart disease/Rheumatic fever			
Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disease, drug, or radiation-induced immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Type I (insulin dependent)			
___ Type II			
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	Don't Know
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, indicate type of infection: _____			
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health disorders. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disorders. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory problems. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Emphysema			
___ Bronchitis, etc.			
Severe headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe or rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sores or ulcers in the mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed above that you think I should know about?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please explain: _____			
_____			

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**  
 I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments on patient interview concerning health history: \_\_\_\_\_

Significant findings from questionnaire or oral interview: \_\_\_\_\_

Dental management considerations: \_\_\_\_\_

**Health History Update:** On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist
_____	_____	_____

***For anyone covered by Dental Insurance:***

**-In the event that the *Covered Amount* approved by your Insurance Company is greater than the fee that we offer you, you and/or your agent will be responsible for the higher amount. In most cases this will be the *Covered Amount*.**

(This is necessary to prevent patients from profiting from submitting insurance claims.)

**-In the event that your Insurance Coverage, *for whatever reason*, denies and/or does not cover a procedure that Dr. Herbst deems necessary for your health and optimal care, you and/or your agent will be responsible to pay that fee(s).**

**By receiving this notice, as a patient in our office, you and/or your agent are made aware of and accept the terms listed above.**

**Thank you for your cooperation.**

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**Signature**

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**Date**