MARSHALL T. LAVIN DDS, PC
ENDODONTIC SPECIALIST

Patient Registration

Patient Information

Date ______________ Referring Dentist ______________

Patient Name ______________ Date of Birth ______________

Address ______________

City ______________ State ______ Zip ______

Email ______________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Employer ______________ City ______________

Job Title ______________

Spouse Name ______________ Spouse Occupation ______________

Have you or any member of your family been treated by Dr. Lavin in the past? Yes No Who? ______________

Responsible Party Information *(Leave blank if patient is responsible party)*

Name of Person Responsible for This Account ______________

Relationship ______________ Date of Birth ______________

Address ______________ Phone ______________

City ______________ State ______ Zip ______

Employer ______________ Work Phone ______________

Primary Dental Insurance Information

Insurance Company ______________

Insured Individual ______________ Self / Spouse / Parent / Other

Social Security # or Insurance ID ______________ Insured DOB ______________

Employer ______________ Group # ______________

Dental History

Reason for Today's Visit ______________

Do you have dental pain? ☐ Yes ☐ No When did your pain begin? ______________

Is the pain... ☐ Increasing ☐ Decreasing ☐ Not Changing Where do you feel pain? ______________

Do any or all of the following trigger your pain? ☐ Cold ☐ Heat ☐ Chewing ☐ Touch

Does your pain begin spontaneously? ☐ Yes ☐ No Does anything relieve your pain? ______________

Which one of the following describes your pain? ☐ Constant ☐ Intermittent ☐ Fluctuating

How would you describe your pain? ☐ Dull Ache ☐ Throbbing ☐ Sharp Shooting

Please mark your present pain level *(0 is no pain, 10 is the worst pain imaginable)*: 0 • • • • 5 • • • • 10

Please mark the highest level of pain you have experienced with this tooth: 0 • • • • 5 • • • • 10

Health Questionnaire

Physician Name ______________________________

Women: Are you... ☐ Pregnant/trying to get pregnant? ☐ Taking oral contraceptives? ☐ Nursing?

Allergies: Are you allergic to any of the following? *(Please check)*

☐ Latex ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Codeine ☐ Local Anesthetics ☐ Other ____________

Medical Alerts: Have you had any of the following medical procedures? *(Please check)*

☐ Joint Replacement ☐ w/ Pre-Med ☐ w/out Pre-Med Joint ____________ Year ______

☐ Heart Valve Replacement Year ______

☐ Biophosphates *(Fosomax, Aredia, Boniva, Zometa, Aclasta, Bonefos, Didronel, Reclast, Skelid)* ☐ Osteoporosis ☐ Chemotherapy

Medical History: Do you have, or have you had any of the following? *(Please check)*

☐ AIDS/HIV Positive	☐ Diabetes	☐ Hepatitis A	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Drug Addiction	☐ Hepatitis B or C	☐ Rheumatism
☐ Anaphylaxis	☐ Easily Winded	☐ Herpes	☐ Scarlet Fever
☐ Anemia	☐ Emphysema	☐ High Blood Pressure	☐ Shingles
☐ Angina	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida
☐ Artificial Joint	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Steroids
☐ Asthma	☐ Frequent Cough	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Blood Disease	☐ Frequent Diarrhea	☐ Liver Disease	☐ Stroke
☐ Blood Transfusion	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Breathing Problem	☐ Genital Herpes	☐ Lung Disease	☐ Thyroid Disease
☐ Bruise Easily	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Cancer	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Attack/Failure	☐ Parathyroid Disease	☐ Tumors or Growths
☐ Chest Pains	☐ Heart Murmur	☐ Psychiatric Care	☐ Ulcers
☐ Cold Sores/Fever Blisters	☐ Heart Pace Maker	☐ Radiation Treatments	☐ Venereal Disease
☐ Congenital Heart Disorder	☐ Heart Trouble/Disease	☐ Recent Weight Loss	☐ Yellow Jaundice
☐ Convulsions	☐ Hemophilia	☐ Renal Dialysis	

Please describe any problems not listed above: ______________________________

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Medications: Are you currently taking any of the following medications? *(Please check)* ☐ Antibiotics ☐ Anticoagulants
☐ Antihistamines ☐ Blood Pressure Medications ☐ Pain Medications ☐ Steroids ☐ Tranquilizers
List of Medications ______________________________

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____

Pharmacy ______________________ Phone ______________

To my knowledge, the answers above are correct.

With my signature, I certify that I have read and understand the financial policy (detailed on a separate sheet), agree to abide by it, and will pay today with one of the following: ☐ Check ☐ Cash ☐ Credit Card ☐ Care Credit

With my signature, I certify that I have had the opportunity to review the office's Notice of Privacy Practices.

With my signature, I certify that I have read and understand the information in the Consent for Endodontic Therapy (details on separate sheet), and I give my consent for treatment.

Signature *(Patient/Guardian)* ______________________ **Date** ______________