SOUTHEASTERN ENDODONTICS

Practice Limited to Endodontics
J. Brian Baker, D.M.D.

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PATIENT REGISTRATION **DATE:_____**

□ Mr. □ Mrs. □ Ms. □ Dr. First Name _____ M.I. _____ Last Name _____

Sex: □ Male □ Female Birth Date _____Soc. Sec. # _____ Nickname_____

Marital Status: □ Married □ Single □ Significant Other Name _____ Home Phone (____)_____

Patient **COMPLETE** Address _____Bus. Phone (____)_____

Apt. _____ City _____ State _____ Zip_____ Cell. Phone (____)_____

Employer _____ Address _____ Preferred Contact □ Text □ Call

City _____ State _____ Zip _____ Have you been to our practice

In case of emergency, please contact _____ Tel. (____)_____ before? □ Yes □ No

Relation _____ Address _____ If so, when? _____

PERSON RESPONSIBLE FOR ACCOUNT Ref. Dentist _____

□ Self (If self, skip this section) □ Spouse □ Father □ Mother □ Other _____

Name _____ _____ S.S. # _____ Birth Date _____ Age _____

Tel. (____)_____ Address _____ Apt. _____ City _____ State _____Zip _____

PRIMARY DENTAL INSURANCE COMPANY

Insurance Company _____

Address _____ _____

City, State, Zip _____ Tel (____)_____

Group # _____

Member ID _____

Member Name _____ _____

Relation _____ Soc. Sec. #_____

Sex: □ M □ F Birth Date _____ Age _____

Employer _____ _____

Bus. Address _____ _____

Bus. Tel. (____)_____ Plan _____

SECONDARY DENTAL INSURANCE COMPANY

Insurance Company _____

Address _____ _____

City, State, Zip _____ Tel (____)_____

Group # _____

Member ID _____

Member Name _____ _____

Relation _____ Soc. Sec. #_____

Sex: □ M □ F Birth Date _____ Age _____

Employer _____ _____

Bus. Address _____ _____

Bus. Tel. (____)_____ Plan _____

MEDICAL HISTORY

Do you have or have you had any of the following diseases, medical conditions, or procedures:

Y N

□ □ Heart Condition
□ □ Heart Valve Problems
□ □ Diabetes
□ □ Liver Disease
□ □ Kidney Disease
□ □ Cancer
□ □ Lung Disease
□ □ HIV/AIDS
□ □ Hepatitis A, B, or C

ALLERGIES:

Are you allergic to or had a reaction to any of the following:

Y N

□ □ Penicillin
□ □ Novocaine
□ □ Aspirin
□ □ Local anesthetic
□ □ Codeine
□ □ Latex
□ □ Sulfa drugs
□ I have no known drug allergies.
□ Other: _____

MEDICATIONS

Are you currently taking any of the following:

Y N

□ □ Blood thinners
□ □ Aspirin therapy
□ □ Coumadin, Warfarin
□ □ Plavix, Effient, Brilinta
□ □ Antibiotics
□ □ Pain medication
□ Other: _____

_____

_____

Is there a possibility of pregnancy? _____ Expected delivery date: _____

For women only: Antibiotics, such as penicillin, may alter the effectiveness of birth control contraceptives. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

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Savannah, Georgia 31405
(912) 352-2289

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Statesboro, Georgia 30458
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