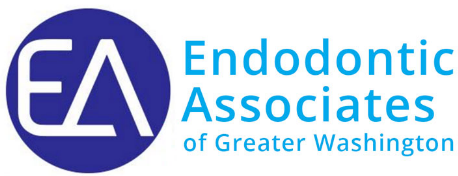

Ian K Walker DDS | Yaser F Roumani DDS
Chetan Yelamanchi DDS | Christopher Jin DMD

Patient Registration Form

PATIENT INFORMATION

First Name		MI		Last Name			
Social Security #		Gender	❑ Male ❑ Female	Birth Date			
Driver's License #		E-mail					
Address		City		State		ZIP Code	
Home Phone		Cell Phone		Work Phone			
Marital Status	❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single						
Employer		Occupation					
Employer Address		City		State		ZIP Code	
Referral By							
General Dentist							
Spouse's Name		Daytime Phone					
Emergency Contact		Daytime Phone					

RESPONSIBLE PARTY (if self is selected, please skip to the next section)

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other: ______________________________

First Name		Last Name		Social Security #			
Birth Date		Age		Telephone			
Address		City		State		ZIP Code	
Employer		Business Telephone					

INSURANCE INFORMATION

Do you have dental insurance?	❑ Yes ❑ No

Insurance Patients Only *(Please check each box and initial after the statement.)*

❑ **I authorize release of any information relating to this claim.** _______

❑ **I wish to assign benefits to the providing Endodontist.** (*Insurance company will send payment to the providing Endodontist.)* _______

PRIMARY DENTAL INSURANCE COMPANY				SECONDARY DENTAL INSURANCE COMPANY			
Primary Policy Holder	First Last			Primary Policy Holder	First Last		
Relation		Gender	❑ Male ❑ Female	Relation		Gender	❑ Male ❑ Female
S.S. #		Birth Date		S.S. #		Birth Date	
Primary Policy Holder Employer				Primary Policy Holder Employer			
Insurance Co. Name				Insurance Co. Name			
Group #		Plan Name		Group #		Plan Name	

HEALTH HISTORY

Physician Name		Physician Phone	
Do you require antibiotics before dental treatment?			❑ Yes ❑ No
If yes, please explain			
Have you been hospitalized in the last 5 years?			❑ Yes ❑ No
If yes, please explain			

Endodontic Associates of Greater Washington

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Patient Registration Form

MEDICATIONS

Please list all medications, over the counter and herbal supplements, that you are currently taking *(include medication name, dosage and frequency)*:

Have you or are you taking any calcium replacement medications (Fosamax, Boniva, etc)**?**	❑ Yes	❑ No
If yes, please explain		

ALLERGIES/REACTIONS

Please list any allergy/reaction that you have or have had.

FOR WOMEN ONLY

Are you pregnant?	❑ Yes	❑ No	**If yes, number of weeks**	

Do you have, or have had, any of the following?

	Yes	No		Yes	No
AIDS, HIV, or high risk			**Malignancies or cancer**		
Blood disorder (describe below)			**Mitral valve prolapse**		
Diabetes			**Osteoporosis**		
Excessive bleeding from a cut or extraction			**Pacemaker or artificial valve**		
Excessive thirst or urination			**Radiation or chemotherapy treatment**		
Glaucoma			**Rheumatic fever**		
Heart disease (angina, heart attack, bypass)			**Shortness of breath**		
Hepatitis or liver problems			**Sinus trouble**		
High or Low blood pressure			**Stroke**		
Hip or joint replacement			**Thyroid or parathyroid condition**		
Kidney disorder			**Ulcer or Colitis**		
Lung disease or Tuberculosis			**Venereal disease**		

Is there any disease, condition, or problem that you think our office should know about that is not listed above? If yes, please list below.	❑ Yes	❑ No

FORM COMPLETION

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:		**Date:**	

IF PATIENT IS A MINOR

Form signed by:		**Relationship to Patient:**	