LPE *Lincoln Park Endodontics*

Patient Registration Form

Patient Name: _____ Phone (Home): ( ) _____

Address: _____ Phone (Cell): ( ) _____

_____ Phone (Work): ( ) _____

_____ Dr. Lic. #_____

Date of Birth: _____ Social Security #: _____-_____-_____

Who Is Your Dentist?_____ Phone: ( ) _____

Address:_____

MEDICAL HISTORY:

1. Physician's Name: _____ Phone: ( ) _____
2. Are you under physician's care now? Yes ☐ No ☐ If Yes, please give reason:
   Treatment:_____
3. Have you had any of the following conditions?

	YES	NO		YES	NO
Heart Attack / Stroke	☐	☐	**Cancer / Chemotherapy**	☐	☐
Heart Murmur / Rheumatic Fever	☐	☐	**HIV / AIDS**	☐	☐
Heart Surgery / Pacemaker	☐	☐	**Drug / Alcohol Abuse**	☐	☐
Mitral Valve Prolapse	☐	☐	**Diabetes: Type 1 or 2**	☐	☐
High Blood Pressure	☐	☐	**Hepatitis: A, B or C**	☐	☐
Abnormal Bleeding	☐	☐	**Tuberculosis / Asthma**	☐	☐
Kidney / Liver Disease	☐	☐	**Joint Implant (Hip, Knee, etc.)**	☐	☐

4. Are you taking medications? Yes ☐ No ☐ If Yes, please list:
   _____
5. Have you had any **unusual** reactions to any of the following compounds?

	YES	NO		YES	NO
Dental Local Anesthetics	☐	☐	**Penicillin / Amoxicillin**	☐	☐
Aspirin	☐	☐	**Clindamycin**	☐	☐
Ibuprofen (Motrin/Advil)	☐	☐	**Tetracycline**	☐	☐
Naproxen (Aleve)	☐	☐	**Latex (Rubber)**	☐	☐
Tylenol with Codeine / Vicodin	☐	☐			

6. Other Allergies:_____
7. Women: Are you pregnant? Yes ☐ No ☐ Breastfeeding? Yes ☐ No ☐
8. How will you pay your co-payment today? Cash Visa / Mastercard Care Credit

_____ _____

SIGNATURE DATE

I acknowledge that I have seen a copy of the privacy policy _____

Initials