



Julie A. Saviano, D.M.D.

Patient Registration

___ Mr. Date: _____
___ Mrs. Birth Date: _____
___ Ms.
Patient ___ Dr. _____ / ____ / _____

Home Address Street: _____
City: _____ State: _____ Zip: _____

Phone: Home: () _____ Business: () _____ Cell: () _____

If patient is a minor, who is legally responsible? _____

In case of emergency, who should we contact? _____

Phone: () _____ Relationship _____

Referring dentist: _____

Insurance Information

Name of Insurance Company: _____ Phone: () _____

Subscriber's Name: _____ SS#: _____

Birth Date: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Group or Policy Number: _____

Is patient covered by additional insurance? ___ Yes ___ No

Name of secondary insurance company: _____ Phone: () _____

Subscriber's Name: _____ SS#: _____

Birth Date: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Group or Policy Number: _____

Health History

Name of Physician: _____ Phone: () _____

Are you in good health? ___ Yes ___ No Date of your last physical exam: _____

Are you presently under the care of a physician? ___ Yes ___ No

If yes, for what condition(s)? _____

In the last five years, have you ever been: (If yes, please explain)

Hospitalized? ___ Yes ___ No _____

Had a serious illness? ___ Yes ___ No _____

Had a major operation? ___ Yes ___ No _____

Have you had, or do you presently have any of the following conditions?

	Yes	No		Yes	No
Heart Disease, Heart Surgery, or Heart Attack ..	___	___	Surgery or x-ray treatment for a tumor, growth, or other condition of the head, mouth or lips...	___	___
Chest Pain/Angina Pectoris.....	___	___	AIDS or HIV Positive.....	___	___
High/Low Blood Pressure.....	___	___	Hepatitis, Jaundice, or Liver Disease.....	___	___
Heart Murmur.....	___	___	Blood Transfusion.....	___	___
Rheumatic Fever/Rheumatic Heart Disease.....	___	___	Drug Addiction/Alcoholism.....	___	___
Congenital Heart Lesions/Mitral Valve Prolapse	___	___	Hemophilia or Excessive Bleeding.....	___	___
Artificial Heart Valve.....	___	___	Glaucoma.....	___	___
Heart Pacemaker.....	___	___	Allergies/Hay Fever.....	___	___
Artificial Joint/Prosthesis.....	___	___	Asthma.....	___	___
Stroke.....	___	___	Sinus Trouble.....	___	___
Kidney Disease.....	___	___	Seizures/Epilepsy.....	___	___
Cancer or Tumors	___	___	Arthritis.....	___	___
Thyroid Disease.....	___	___	Phen-Fen or Redux Diet.....	___	___
Lung Disease/Tuberculosis.....	___	___	Ulcer.....	___	___
Diabetes.....	___	___	Cold Sores/Herpes.....	___	___
Jaw Joint (TMJ) Problems.....	___	___			

Have you ever had an allergic reaction to any of the following?

	Yes	No		Yes	No
Local Anesthetics ("Novocaine").....	___	___	Penicillin	___	___
Aspirin or Ibuprofen (Advil)	___	___	Erythromycin or other Antibiotics ..	___	___
Acetaminophen (Tylenol).....	___	___	Sulfa Drugs	___	___
Codeine or Other Narcotics	___	___	Any Other Medications or Drugs....	___	___
Latex Rubber Materials	___	___	Which Ones? _____		

Women:

	Yes	No	
Are You Pregnant?	___	___	If Yes, How Many Months? _____
Are You Breastfeeding?	___	___	
Are You Taking Birth Control Pills?	___	___	

If you are taking birth control pills, please read the following: Antibiotics may inactivate birth control medication. Therefore, if you are prescribed antibiotics during endodontic treatment, additional birth control methods should be used until your next menses.

Please list any medications (over the counter, prescription, or herbal/alternative) that you are now taking: _____

If you have had any serious complications involving dental treatment, please explain:

Informed Consent: I understand that Root Canal Treatment is a procedure to retain a tooth which may otherwise require extraction. Occasionally, a patient may experience post-operative discomfort or swelling which may require medication for several days. Although Root Canal Therapy 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 Root Canal Therapy may require retreatment, surgery, or even extraction.

Patient (or Guardian) Signature

Date