Root Canal RCDT Dental Trauma Center

Patient Information

Name_____ DOB_____/_____/_____
Last First Middle

Social Security# _____-_____-_____ Sex: M ☐ F ☐ Unk ☐ Marital Status ☐M ☐S ☐Divorced ☐N/A

Address_____ Apt#_____

City_____State_____Zip Code_____Driver's License # _____

Cell (_____) _____-_____ Home Phone (_____) _____-_____

"By providing my phone number, I consent to receive SMS text messages from Root Canal & Dental Trauma Center for appointment reminders, marketing messages, and general two-way communication. Msg frequency varies. Msg&data rates may apply. Reply HELP for support. Reply STOP to opt out. Please check our privacy policy and terms and conditions for details at (www.RCDTcenter.com/privacy-policy and www.RCDTcenter.com/terms-and-conditions)". ☐ _____
SMS Text Consent Signature

Email_____ Driver's License #_____

Employer/ School _____ Employer/School Phone (_____) _____-_____

Who may we thank for referring? _____

Emergency Contact _____ Phone (_____) _____-_____

Responsible Party (If same as above, please skip, if parent, please fill out) _____
Relation to patient

Name_____ DOB_____/_____/_____
Last First Middle

Social Security# _____-_____-_____ Sex: M☐ F☐ Unk☐ Driver's License # _____

Address_____ Apt#_____

City_____State_____ Zip Code_____ County_____

Cell (_____) _____-_____ Home Phone (_____) _____-_____

"By providing my phone number, I consent to receive SMS text messages from Root Canal & Dental Trauma Center for appointment reminders, marketing messages, and general two-way communication. Msg frequency varies. Msg&data rates may apply. Reply HELP for support. Reply STOP to opt out. Please check our privacy policy and terms and conditions for details at (www.RCDTcenter.com/privacy-policy and www.RCDTcenter.com/terms-and-conditions)". ☐ _____
SMS Text Consent Signature

Email_____ Driver's License #_____

Employer/ School _____ Employer/School Phone (_____) _____-_____

Who may we thank for referring? _____

Emergency Contact _____ Phone (_____) _____-_____

Insurance Information

Policy Holder Name _____ DOB _____/_____/_____

Member Id or Social Security # _____ Group # _____

Insurance Name _____ INS phone # (_____)-_____-_____

Insurance Address _____ City_____ State _____

Employer Name _____ Employer Phone # (_____) _____-_____

Dental History

Reason for today's Visit? _____ Date of last Dental Visit _____ /_____ /_____

How often do you Brush? _____ How often do you Floss? _____

Check if you have had any of the following problems:

☐Bad Breath ☐Sensitivity to hot ☐ Bleeding Gums ☐ Sensitivity to cold

☐ Grinding teeth ☐ Food collection between teeth ☐ Clicking or popping Jaw ☐ Loose teeth or broken teeth

Medical History

Are you under a Physician's care now? (If yes, explain) _____

Have you ever taken Phen-Fen or Redux? (If yes, explain)_____

Have you ever been hospitalized or had any major operations? If yes, explain

_____

Have you ever had a serious head or neck injury? If yes, explain

_____

Have you ever taken Fosamax, Boniva, Actonel, or any medication containing bisphosphonates? (If yes, explain)

_____

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Latex
☐ Acrylic	☐ Metal	☐ Sulfa Drugs	☐ Local Anesthetics

If Yes Explain_____

If you are taking any medications, please list them: _____

_____

If you have any of the following conditions, check:

☐ Anemia	☐ Arthritis	☐ Artificial Heart Valve	☐ Asthma
☐ Artificial Joints	☐ Blood diseases	☐ Blood transfusion	☐ Cancer
☐ Chemotherapy	☐ Chest Pains	☐ Cold sores	☐ Convulsions
☐ Diabetes	☐ Epilepsy	☐ Emphysema	☐ Excessive Bleeding
☐ Fainting	☐ Frequent cough	☐ Frequent Diarrhea	☐ Frequent Headache
☐ Glaucoma	☐ Heart Murmur	☐ Heart Problems	☐ Hepatitis A
☐ Hepatitis B/C	☐ Herpes	☐ High Blood Pressure	☐ HIVS
☐ Pacemaker	☐ High Cholesterol	☐ Hypoglycemia	☐ Hemophilia
☐ Kidney Disease	☐ Liver Disease	☐ Leukemia	☐ Low blood pressure
☐ Lung Disease	☐ Osteoporosis	☐ Thyroid Disease	☐ Respiratory Disease
☐ Rheumatism	☐ Renal Dialysis	☐ Radiation Treatment	☐ Mitral Valve Prolapse
☐ Scarlet Fever	☐ Shingles	☐ Sinus Trouble	☐ Skin Rash
☐ Short breath	☐ Stroke	☐ Spina Bifida	☐ Stomach Disease
☐ Swelling Limbs	☐ Tonsillitis	☐ Tobacco Habit	☐ Tuberculosis
☐ Ulcers	☐ Venereal Disease	☐ Yellow Jaundice	☐ Pregnant

Have you ever had any serious illness not listed above? (If YES explain)

_____

Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have any health change.

_____ _____ / _____ / _____

Signature of Patient, Parent, or Guardian Date