Gordon L. Barkley III, D.M.D., M.S., Endodontic Specialists, P.C.

Patient Registration Form

Date: ______________________ Referring Dentist: ______________________________________

Patient Name: ____ Nick Name_________________

Address: ____

City: _____________________________ State: ________________ Zip: _____________________

Cell Phone: ____________________________ Home Phone: ______________________________

Social Security #: ______________________ Date of Birth: ______________________________

Marital Status: Single Married Separated Divorced Widowed

Email Address: ____

Employer: ____ Phone: ______________________

Emergency Contact: _________________________________ Phone: ______________________

Physician Name: ______________________________________ Phone: ______________________

Have you been treated by Dr. Barkley in the past: YES NO If so, when? _____________

How did you hear about us? ____

PRIMARY DENTAL INSURANCE INFORMATION, if NONE leave blank:
Employee _________________________ Self / Spouse / Parent / Other Date of birth ____________________
SocialSecurity#orID#_______________________ Group# _____________________________________
Employer _________________________________ Employer Phone________________________________
Employer Address ____
Insurance Company ____

SECONDARY DENTAL INSURANCE INFORMATION, if NONE leave blank:
Employee _________________________ Self / Spouse / Parent / Other Date of birth ____________________
SocialSecurity#orID#_______________________ Group# _____________________________________
Employer _________________________________ Employer Phone________________________________
Employer Address ____
Insurance Company ____

____ ___________________________

Signature of Patient, Parent Or Guardian *Date*

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Patient Medical Health History Form

Patient Name: ____ Date: _______________

Date of Birth: ___________________________ Age: ______________ Sex: Male / Female

List All Current Medications (Prescribed and OTC): ________________________________

____

List All Drug Allergies (Medications, Environmental, Foods):________________________

____

Are you allergic to latex or rubber gloves? . . . . YES NO

Have you ever had an adverse reaction to local anesthetic? . . . . YES NO

Have you ever had any excessive bleeding requiring special treatment? . . . .YES NO

Circle any of the following, which you have had or currently have:

Heart Attack	Stroke	Thyroid Disease	Colitis
Angina Pectoris	Kidney Trouble	Radiation Therapy	Liver Disease
High Blood Pressure	Ulcers	Chemotherapy	Blood Transfusion
Heart Murmur	Cancer	Arthritis	Drug Addiction
Mitral Valve Prolapse	Emphysema	Cortisone Medication	Alcohol Addiction
Artificial Heart Valve	Asthma	Glaucoma	Hemophilia
Heart Pacemaker	Hay Fever	Pain in Jaw Joints	Venereal Disease
Heart Surgery	Sinus Trouble	Migraine	Cold Sores
Artificial Joint	Allergies or Hives	HIV	Epilepsy or Seizures
Rheumatic Fever	Diabetes Type 1	AIDs	Fainting or Dizzy Spells
Anemia	Diabetes Type 2	Hepatitis – Type ____	Psychiatric Treatment

Do you have any disease or condition not listed? ___________________________________

WOMEN: Are you pregnant: YES NO If so, how many weeks? ____________________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the office without fail.

____ ________________________

Signature of Patient, Parent Or Guardian *Date*