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: Sta		ate:	Zip:			
Cell Phone:		Home Phone:				
Social Security #:		Date of Birth:				
Marital Status: Sin	gle Married	Separated	Divorced Widowed			
Email Address:						
imployer: Phone:						
Emergency Contact:		Phone:				
Physician Name: Phone:						
Have you been treat	ed by Dr. Barkley	in the past: Y	YES NO If so, when?			
How did you hear ab	out us?					
SocialSecurity#orID# Employer Employer Address	Self	/ Spouse / Parent / (Group# Employer	Other Date of birthPhone			
SECONDARY DENTAL IN EmployeeSocialSecurity#orID#	ISURANCE INFORM. Self	ATION, if NONE l / Spouse / Parent / (Group# Employer	leave blank: Other Date of birth Phone			
Signature of Patient,	Parent Or Guard	 ian	 Date			

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

Patient Medical Health History Form

Are you allergic to latex or rubber gloves?	Patient Name:		Date:		
List All Drug Allergies (Medications, Environmental, Foods):	Date of Birth:		_ Age:	Sex: Male / Female	
Are you allergic to latex or rubber gloves?	List All Current Medi	cations (Prescribed	and OTC):		
Have you ever had an adverse reaction to local anesthetic?	List All Drug Allergies	s (Medications, Envi	ronmental, Foods):		
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? WOMEN: Are you pregnant: YES NO If so, how many weeks?	Are you allergic to lat	ex or rubber gloves	?	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	Have you ever had an	adverse reaction to	local anesthetic?	YES NO	
Heart Attack 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 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 MOMEN: 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	Have you ever had an	ny excessive bleeding	g requiring special tro	eatment?YES NO	
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	Circle any of the follo	wing, which you hav	ve had or currently ha	ave:	
	WOMEN: Are you pre	Kidney Trouble Ulcers Cancer Emphysema Asthma Hay Fever Sinus Trouble Allergies or Hives Diabetes Type 1 Diabetes Type 2 ase or condition not egnant: YES NO Integrate of the preceding of the p	Radiation Therapy Chemotherapy Arthritis Cortisone Medication Glaucoma Pain in Jaw Joints Migraine HIV AIDs Hepatitis - Type f so, how many weeks ag answers are true and be, I will inform the office	Liver Disease Blood Transfusion Drug Addiction Alcohol Addiction Hemophilia Venereal Disease Cold Sores Epilepsy or Seizures Fainting or Dizzy Spells Psychiatric Treatment	