TREASURE VALLEY
ENDODONTICS

PATIENT REGISTRATION

Name: _____ ❒ Male ❒ Female
First / MI / Last

❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Social Security #: _____ - _____ - _____ Birthdate: _____ / _____ / _____

Home Address: _____ Emergency Contact: _____

_____ Emer. Contact phone #: (____) _____-_____
City State Zip

E-mail Address: _____

Home Phone #: (____) _____ - _____ Cell/Alternate Phone #: (_____) _____ - _____

Employer Name (if applicable): _____ Work Phone: (_____) _____ - _____

Employer Address: _____
Street or P.O. Box

_____
City State Zip

Occupation: _____

Insurance Carrier: _____

Have we treated other members of your family? ❒ No ❒ Yes, Name: _____

SPOUSE/PARENT INFORMATION

Name: _____ Birthdate: _____ / _____ / _____ SSN: _____ - _____ - _____

Employer: _____ Work Phone: (_____) _____ - _____ Cell: (_____) _____ - _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, you consent to the use and disclosure of your protected health information by Stanton D. Widmer, D.D.S., our staff, and our business associates for treatment, payment, and health care operations. For a detailed description of uses and disclosures for these purposes, please review our Notice of Privacy Practices. The terms of this notice may change in the future. If the terms do change, you may obtain a revised Notice by simply contacting this office at 208-454-3636. We will post any revised Notice in the office. You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to use for treatment, payment, and health care operations, although we are not required to agree to these restrictions. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your protected health information.

I HAVE REVIEWED, UNDERSTAND, AND AGREE TO THE CONTENT OF THE PRIVACY NOTICE.

_____ _____
Signature of patient, parent, or guardian **DATE**

4207 Clocktower Avenue, Caldwell, ID 83607 P: (208) 454-ENDO (3636) F: (208) 454-1333

TREASURE VALLEY
ENDODONTICS

HEALTH HISTORY

Medical Physician's Name: _____ Phone: (_____) _____ - _____

Do you now or have you ever had any of the following (circle all that apply):

A. **Cardiovascular System**:
1. Infective endocarditis. . . . . YES NO
2. Congenital heart disease (heart murmur). YES NO
3. Prosthetic heart valve. . . . . YES NO
4. High or low blood pressure. . . . . YES NO
5. Heart attack, disease, or surgery . . . . . YES NO
6. Chest pain (angina). . . . . YES NO
7. Stroke. . . . . YES NO

B. **Nervous System:**
1. Epilepsy, seizures, or fainting. . . . . YES NO
2. Neuritis, neuralgia, or numbness. . . . . YES NO
3. Psychological disorders, depression. . . . . YES NO

C. **Respiratory System**:
1. Tuberculosis. . . . . YES NO
2. Pneumonia, asthma, emphysema, COPD. YES NO
3. Sinus trouble, hay fever, allergies. . . . . YES NO
4. Tobacco use (including smokeless). . . . . YES NO

D. **Genitourinary and Gastrointestinal Systems:**
1. Kidney disease. . . . . YES NO
2. Liver disease, jaundice, or hepatitis. . . . . YES NO
3. Stomach or intestinal problems. . . . . YES NO
4. Ulcers, reflux disease. . . . . YES NO
5. Eating disorders. . . . . YES NO

E. **Endocrine System**:
1. Diabetes. . . . . YES NO
2. Thyroid disease. . . . . YES NO

F. **Musculoskeletal System (Bones & Joints):**
1. Arthritis (osteo or rheumatoid). . . . . YES NO
2. Joint replacement. . . . . YES NO
3. Back, neck, or jaw injury. . . . . YES NO

G. **Hematologic System (Blood & Lymphatics)**:
1. Blood disorder or anemia. . . . . YES NO
2. Abnormal bleeding or bruising . . . . . YES NO

H. **Infectious Disease**:
1. Hepatitis (B C Other). . . . . YES NO
2. Sexually transmitted diseases . . . . . YES NO

I. **Allergic (swelling, rash) & Adverse Reactions:**
1. Latex. . . . . YES NO
2. Penicillin. . . . . YES NO
3. Other antibiotic: _____. . . . YES NO
4. Aspirin. . . . . YES NO
5. Local anesthetic: _____. . . . YES NO
6. Other: _____. . . . YES NO

J. **Miscellaneous**:
1. Have you ever taken bisphosphonates?. . YES NO
2. Have you ever taken steroids?. . . . . YES NO
3. Have you ever had radiation therapy?. . . . YES NO
4. Alcohol or drug use. . . . . YES NO
5. Cancer. . . . . YES NO
6. Blood transfusion. . . . . YES NO
7. Disorders of sensory organs . . . . . YES NO
8. Significant oral and/or facial pain. . . . . YES NO
9. Oral sores. . . . . YES NO
10. Immunosuppressive condition. . . . . YES NO
11. Hospitalization in the past 5 years. . . . . YES NO

K. **For Women Only**:
1. Is there a chance you could be pregnant? YES NO
2. Are you nursing an infant?. . . . . YES NO

Medications: Please list all substances (including supplements and OTC or prescription medications) you take or should be taking:

Drug Name	Dose	How Often?	Reason for Taking

If unable to list all medications above, please request and complete a Supplemental Medication List from our receptionist

My signature certifies that the health information I have provided is complete and accurate. I agree to inform Stanton D. Widmer, D.D.S. of any changes in my medications or health prior to any future treatment.

_____ _____

Signature of patient, parent, or guardian Date

4207 Clocktower Avenue, Caldwell, ID 83607 P: (208) 454-ENDO (3636) F: (208) 454-1333

TREASURE VALLEY
ENDODONTICS

Supplemental Medication List

Medications: Please list all substances (including supplements and OTC or prescription medications) you take or should be taking:

Drug Name	Dose	How Often?	Reason for Taking

If unable to list all medications above, please request and complete a Supplemental Medication List from our receptionist

My signature certifies that the health information I have provided is complete and accurate. I agree to inform Stanton D. Widmer, D.D.S. of any changes in my medications or health prior to any future treatment.

Signature (of parent or guardian if a minor): _____ Date: _____

4207 Clocktower Avenue, Caldwell, ID 83607 P: (208) 454-ENDO (3636) F: (208) 454-1333