Brett A. Rosenberg, DDS, PA
Practice Limited to Endodontics

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Patient Registration and Health History Form

Please use black pen only.

Circle title: Mr. Ms. Mrs. Dr. Other:____________________________

Name:____________ ____

First Middle Initial Last

Sex (circle): F M Date of Birth: / / Social Security # ____________________

Phones: Home: ________________ Business: _______________ x____ Cell: ____________________

Street: ____

City: ____State: ___________ Zip: __________________

Discomfort (circle): None Slight Slight-Moderate Moderate Moderate-Severe Severe

General Dentist: ______________________Referred By: ______________________________________

(first and last name) (Please write "same" if referred by general dentist)

Other Dental Specialists you see (ie; Periodontist):____

Physician: ____ Phone: __________________________

In case of emergency contact: __________________________ Phone: __________________________

Email address:____________________

Please fill out the following questions to the best of your knowledge. Although endodontists primarily treat the mouth area, m problems or medication could have a significant impact on your dental treatment. Your answers are for our records only ar confidential.

Height: ____________

Weight: ____________

Have there been any changes in your general health in the past year? Yes No

Are you under the care of a physician? Yes No

If so, for what are you being treated? __________________________

Date of last medical examination? ____________________________

Have you had any illness, operation or been hospitalized in the past five years? Yes No

Do you have any unhealed injuries, inflamed areas, growths in or around your mouth? Yes No

If so, describe where: _____________________________________

Do you have a prosthetic joint? Yes No

If so, describe where: _____________________________________

Do you have a heart valve replacement or vascular graft? Yes No

If so, describe where: _____________________________________

Have you had or do you currently have…(Please circle)

Damaged heart valves/mitral valve prolapse/ heart murmur
Rheumatic Fever/Rheumatic Heart Disease (RHD)

High blood pressure or low blood pressure

Chest pain, angina

Stroke/Transient Ischemic Attacks

Thyroid trouble

Diabetes

Low blood sugar

Kidney trouble/dialysis

Heart attack

Irregular heart beat

Cardiac pacemaker/implanted defibrillator

Heart surgery/ bypass surgery

Bronchitis/chronic cough

Asthma

Hay fever/sinus problems

Bruise easily

Jaundice/hepatitis/liver disease

Infectious mononucleosis

Gallbladder trouble

Swollen ankles/arthritis/joint disease

Stomach ulcers/irritable bowl disorder/colitis

Contagious diseases

Sexually transmitted diseases

Immune system problems

Delay in healing

Tumor or growth, breast surgery of any type

X-ray treatment or chemotherapy/cancer

Chronic fatigue

Are you on a diet? yes no

Do you smoke? yes no

Tuberculosis	History of drug abuse/"recreational" drug use (cocaine, etc.)
Emphysema/COPD	Malignant hyperthermia
Difficulty breathing or other lung trouble	Eye disease/glaucoma
Blood transfusion	Mental health problems
Blood disorders such as anemia/bleeding disorder	Pain and/or clicking of jaw when eating/TMD/ TMJ
	Convulsions/epilepsy

Do you have any other health problems not listed above? Yes No

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Medication: Please list all medicine, drugs, pills, and over-the-counter medications you have t within the last year:

Circle any herbal medicines you are taking: Echinacea, Ephedra, Garlic, Ginkgo, Ginseng, Kava, St. John's wort, Valerian

Have you ever taken…(Please Circle)

Diet pills	Antidepressants
Anticoagulants	Cortisone
Tranquilizers	

Allergies: Are you allergic to or had a reaction to…(Please Circle)

Local anesthetics (novocaine, adrenalin)	Codeine or other narcotics
Penicillin	Other medications
Other antibiotics	Latex
Aspirin	Please list any allergies other than drugs

All Patients:

Is there any health condition about which the doctor should know? Yes No

Do you wish to speak to the doctor privately about anything? Yes No

Women:

Are you pregnant? If yes, estimated delivery date: ____________________________ Yes No

Is there a possibility of pregnancy? Yes No

Are you nursing? Yes No

Please note that any antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult physician/gynecologist for assistance regarding additional methods of birth control.

Patient Signature: ____ Date: ____________________________

Doctor Signature: ____

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