REGISTRATION FORM

PLEASE PRINT

Date___________________

Patient Name ____

SS #____

Address ____

Name of Spouse/Parent________________________________

City ____________________________________ Zip ___________

Spouse or Parent's Occupation____________________ Work Phone #_____________

Home Telephone # _______________________ Birth Date ________ Sex _____

Employed by____

❑Single ❑Married ❑Widowed ❑Other

Employer's Address_____________________________________

Your Occupation __________________________ Work Phone #_____________

Have you been a patient in this office before?_______________

Referred by____

Employed by____

General Dentist____

Employer's Address ______________________________________

Physician____

Whom may we contact in the case of an emergency? ____

Their Phone #____ Patient's Cell # ____

INFORMED CONSENT

I understand Root Canal treatment is a procedure to retain a tooth which may otherwiserequire extraction. Although Root Canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has Root Canal therapy may require retreatment, surgery, or even extraction.

I also understand that I may be given injections of local anesthetics. Occasionally, during these injections, I understand that the needle can injure a nerve to my tongue or lipleading to tempoary, prolonged, or permanent loss of feeling along the path of the nerve.

I also understand that only the Root Canal treatment is to be performed at this office. The permanent (outside) restoration (filling, onlay, crown, etc.) will be done by my regular dentist.

I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT or BEFORE COMPLETION of treatment.

I will be paying today by Cash _______ Check _______ Credit Card _______ Ins. _______

Signed PATIENT, PARENT or AGENT ____