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STATE ENDODONTICS Marc J. Hertzberg DMD MS

DENTAL REGISTRATION

ABOUT YOU

Patient Name:_____ SS# _____

Street Address:_____City_____State_____Zip_____

Home Phone:_____Work Phone:_____Cellphone_____

Sex ☐ M ☐ F Date of Birth_____ ☐ Single ☐ Married ☐ Separated ☐ Divorced

Employer Name:_____ Address:_____

Occupation:_____

Spouse's Name:_____Spouse's Employer:_____

Who may we thank for referring you?_____

FOR OUR INSURED PATIENTS

Primary Subscriber Name:_____SS#_____ Date of Birth_____

Address:_____City_____State_____Zip_____

Employer:_____Address:_____

Insurance Company_____Group #:_____

Is there secondary insurance? If so complete the following:

Subscriber's name_____SS#_____

Date of Birth:_____Insurance Company:_____

Group #:_____

I authorize release of any information regarding my treatment to my insurance company

_____ _____

Patient or Subscriber (if present) Date

EMERGENCY CONTACT INFORMATION

Name:_____Relationship_____

Home Phone:_____Work Phone:_____

Reason for today's visit:_____

General Dentist:_____

Place a mark on "yes" or "no" to indicate if you currently have had any of the following:

	Y	N		Y	N		Y	N
Burning/Numbness sensation on tongue, lip, cheek	☐	☐	**Mouth pain, brushing**	☐	☐	**Chew on one side of mouth**	☐	☐
Clicking or popping jaw	☐	☐	**Pain around ear**	☐	☐	**Grinding teeth**	☐	☐
Sensitivity to cold	☐	☐	**Sensitivity to hot**	☐	☐	**Sensitivity to sweets**	☐	☐
Sensitivity when biting	☐	☐	**Swollen/Tender gums**	☐	☐	**Jaw Pain or tiredness**	☐	☐
Loose teeth or broken filling	☐	☐						