HIGHLAND PARK ENDODONTICS, LTD.

600 CENTRAL AVENUE SUITE 250 HIGHLAND PARK, ILLINOIS 60035 (847) 433-5155

NAME____ PHONE _______________________ DATE_________________

ADDRESS____ CELL PHONE:_______________________________

CITY, STATE, ZIP____ DATE OF BIRTH: _________________________

SOCIAL SECURITY NO. _________________________________ DRIVERS LICENSE NO. ___________________________________

EMPLOYER________________________________ PHONE____________________ OCCUPATION ________________________

MARITAL STATUS__________________________________ NAME OF SPOUSE____

SPOUSE'S EMPLOYER & PHONE____

GENERAL DENTIST____

PHYSICIAN'S NAME (M.D.) ____ PHONE OR HOSPITAL__________________________

HAS THE PATIENT BEEN HERE BEFORE?__________________ HAVE YOU EVER HAD A ROOT CANAL BEFORE?______________

METHOD OF PAYMENT: CASH__________________ CHECK __________________ CREDIT CARD________________________

IF PATIENT IS A MINOR PLEASE FILL IN THE FOLLOWING FOR THE PERSON RESPONSIBLE FOR PAYMENT:

NAME: ____

ADDRESS____ CITY, STATE, ZIP ____________________________________

SOCIAL SECURITY NO. _________________________________ DRIVERS LICENSE NO. ___________________________________

EMPLOYER__________________________________ PHONE____________________ OCCUPATION ______________________

CHECK ALL THAT APPLY

___ PACEMAKER
___ HEART DISEASE / ATTACK
___ CHEST PAIN / ANGINA
___ CONGENITAL HEART DISEASE
___ HEART MURMUR
___ MITRAL VALVE PROLAPSE
___ HIGH BLOOD PRESSURE
___ STROKE
___ PROSTHETIC VALVES / JOINTS
___ LUNG DISEASE / TUBERCULOSIS
___ ENLARGED LYMPH NODES
___ JAUNDICE / LIVER DISEASE
___ HEPATITIS
___ DIABETES
___ EXCESSIVE URINATION / THIRST
___ KIDNEY / BLADDER DISEASE
___ NEUROLOGIC PROBLEMS
___ ULCERS
___ COLITIS
___ HIVES / SKIN RASH
___ EPILEPSY / SEIZURES
___ ANEMIA / BLOOD PROBLEMS
___ EXCESSIVE BLEEDING
___ CANCER / LEUKEMIA
___ GLAUCOMA
___ THYROID PROBLEMS
___ BRUISE EASY
___ ASTHMA / HAY FEVER
___ SINUS PROBLEMS
___ ALLERGIES
___ ARTHRITIS
___ RHEUMATIC FEVER
___ AIDS
___ BLOOD TRANSFUSIONS

_____**NONE OF THE ABOVE**

HAVE YOU EVER TAKEN BISPHOSPHONATES: FOSAMAX, BONIVA, ACTONEL, OR LIKE MEDICATIONS:? IF SO, WHICH ONES:?

____

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING : ____

____

HAVE YOU HAD AN UNUSUAL OR ALLERGIC REACTION TO ANY MEDICATIONS? IF SO, WHICH ONES:

____

OTHER INFORMATION ABOUT YOUR MEDICAL HISTORY YOU THINK WE SHOULD KNOW :

____

WOMEN: ARE YOU PRESENTLY TAKING BIRTH CONTROL PILLS? **YES** **NO**

ARE YOU PREGNANT? **YES** **NO** IF SO, WHAT MONTH? ____________________________________

NAME AND PHONE NUMBER OF YOUR OBSTETRICIAN: ______________________________________

SIGNED: ____ DATE: _______________________