# 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: ____________________

SS# *(optional)* ________________________DRIVERS LICENSE *(optional)*____________________

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 TO OUR OFFICE OR TREATED BY HIGHLAND PARK ENDODONTICS 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 ____________________

SS# *(optional)* ________________________DRIVERS LICENSE *(optional)*____________________

EMPLOYER & PHONE______________________________OCCUPATION ____________________

## CHECK ALL THAT APPLY

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

________ **NONE OF THE ABOVE**

PLEASE LIST ALL **MEDICATIONS YOU ARE PRESENTLY TAKING** ______________________________

______________________________________________

______________________________________________

PLEASE LIST ALL **DRUG ALLERGIES** AND/OR **UNUSUAL REACTIONS TO MEDICATIONS** OR **LATEX**__________________

______________________________________________

HAVE YOU EVER TAKEN **BISPHOSPHONATES***: FOSAMAX, BONIVA, ACTONEL, ETC*? **YES** **NO** IF SO WHICH ONES:

______________________________________________

PLEASE LIST 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** WHAT MONTH? ________ NAME of OB/GYN: ____________________

**SIGNED:** ______________________________ **DATE:** ____________________