**Martin J. Rogers,** D.D.S.
**Matthew C. Davis,** D.D.S.

*Thank you*

On behalf of Best Endodontics of Glenview we would like to thank you for taking the time to complete the Patient Registration Form.

After completing the form, please save the file to your desk top and return to us using any one of the following methods:

**EMAIL**
Email the document to info@bestendoglenview.com

**MAIL**
Print the completed document and mail to: Best Endodontics of Glenview, Attention Dr. Martin Rogers, 1775 Glenview Road, Suite 217, Glenview, Illinois 60025

**FAX**
Print the completed document and fax to 847.729.8408

Best Endodontics of Glenview
MICROSCOPIC ROOT CANAL THERAPY

# PATIENT REGISTRATION

Date___________________________

## *Personal Information*

Last Name_______________________________________ First______________________________ Middle_____

Home Address___________________________________________ City___________________________________

State______________________ Zip_____________ Social Security No.____________________________________

Home Ph.________________________ Work Ph.________________________ Cell Ph. ______________________

Date of Birth _____/______/___________ Marital Status: Married ___ Single ___ Widow ___

Employer_________________________________________________ Occupation ___________________________

Business Address_____________________________________________ Bus. Ph. ____________________________

Spouse Name _________________________________________________________________________________

Employer ____________________________________________________________________________________

Business Address_____________________________________________ Bus. Ph. ____________________________

Dentist Name ______________________________________________ Phone ______________________________

Dentist Address _______________________________________________________________________________

City ____________________________________________ State _______________________ Zip _____________

## *Guarantor Information*

Name__________________________________________________ Relationship_____________________________

Home Address___________________________________________ City___________________________________

State______________________ Zip_____________ Social Security No.____________________________________

Home Ph.________________________ Work Ph.________________________ Cell Ph. ______________________

## *Dental Insurance*

Primary Dental Insurance___________________________ Employer ______________________________________

Subscriber Name_________________________________________________ ID ____________________________

Subscriber Date of Birth _____/______/___________

Secondary Dental Insurance___________________________ Employer_____________________________________

Subscriber Name_________________________________________________ ID ____________________________

Subscriber Date of Birth _____/______/___________

Best Endodontics of Glenview
MICROSCOPIC ROOT CANAL THERAPY

# PATIENT REGISTRATION

Date___________________________

## *Medical History*

Are you under a Physician's care for a long term illness? Y ____ N ____

If yes please explain: ______________________________________________________________

*Do you premedicate for dental procedures? Y ____ N ____
*Premedicating is a standing order by your attending physician to take antibiotics before ALL dental procedures due to an existing medical condition.

For Women: Are you pregnant? Y ____ N ____
Are you nursing? Y ____ N ____

Have you ever had any of the following diseases or medical conditions?

| Condition | Y | N | Condition | Y | N |
|---|---|---|---|---|---|
| Abnormal Bleeding | Y ____ | N ____ | Herpes/Fever Blisters | Y ____ | N ____ |
| Alcohol/Drug Abuse | Y ____ | N ____ | High Blood Pressure | Y ____ | N ____ |
| Anemia | Y ____ | N ____ | HIV+/AIDS | Y ____ | N ____ |
| Arthritis | Y ____ | N ____ | Hospitalized for any reason | Y ____ | N ____ |
| Asthma | Y ____ | N ____ | Kidney Problems | Y ____ | N ____ |
| Cancer/Chemotherapy | Y ____ | N ____ | Liver Disease | Y ____ | N ____ |
| Congenital Heart Defect | Y ____ | N ____ | Low Blood Pressure | Y ____ | N ____ |
| Diabetes | Y ____ | N ____ | Mitral Valve Prolapse | Y ____ | N ____ |
| Difficulty Breathing | Y ____ | N ____ | Nervous/Anxiety | Y ____ | N ____ |
| Emphysema | Y ____ | N ____ | Pacemaker | Y ____ | N ____ |
| Epilepsy | Y ____ | N ____ | Psychiatric Problems | Y ____ | N ____ |
| Heart Attack | Y ____ | N ____ | Radiation Treatment | Y ____ | N ____ |
| Heart Murmur | Y ____ | N ____ | Seizures | Y ____ | N ____ |
| Heart Surgery | Y ____ | N ____ | Sinus Problems | Y ____ | N ____ |
| Hemophilia | Y ____ | N ____ | Stroke | Y ____ | N ____ |
| Hepatitis | Y ____ | N ____ | Tuberculosis | Y ____ | N ____ |
| Heart Valve or Joint Replacement | Y ____ | N ____ | | | |

Please list any additional serious medical conditions_______________________________________

Are you allergic to any of the following?

| Allergen | Y | N | Allergen | Y | N |
|---|---|---|---|---|---|
| Aspirin | Y ____ | N ____ | Latex | Y ____ | N ____ |
| Codeine | Y ____ | N ____ | Penicillin | Y ____ | N ____ |
| Epinephrine | Y ____ | N ____ | Sulfa | Y ____ | N ____ |
| Erythromycin | Y ____ | N ____ | Ibuprofen | Y ____ | N ____ |

Please list any additional medicine allergies ____________________________________________

Are you currently taking or have you ever taken any of the following medications:

| Medication | Y | N | Medication | Y | N |
|---|---|---|---|---|---|
| Zoledronate (Zometa) | Y ____ | N ____ | Pamidronate (Aredia) | Y ____ | N ____ |
| Clodronate (Bonefos) | Y ____ | N ____ | Ibandronate ( Boniva) | Y ____ | N ____ |
| Risedronate (Actonel) | Y ____ | N ____ | Alendronate (Fosamax ) | Y ____ | N ____ |
| Tiludronate (Skelid) | Y ____ | N ____ | Etidronate (Didronel) | Y ____ | N ____ |
| Neridronate | Y ____ | N ____ | Olpadronate | Y ____ | N ____ |
| Reclast | Y ____ | N ____ | Alclasta | Y ____ | N ____ |

Please list any additional medication you are taking ___________________________________________

Signed ____________________________________________________________________