Best Endodontics *of Glenview*

MICROSCOPIC ROOT CANAL THERAPY

Martin J. Rogers, D.D.S.
Matthew C. Davis, D.D.S.
Paulina Erdle, D.M.D.
John Tran, D.M.D., M.S.

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 ______________________

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 _____/______/____________

1775 Glenview Road, Suite 217 | Glenview, Illinois 60025 | T 847 729 8400 | F 847 729 8408
www.Bestendoglenview.com

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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____

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