Northern Illinois Endodontics, Ltd.

(Please Print) Date_____

Name_____ Nickname (if preferred) _____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Social Security No._____ Date of Birth_____ Age_____

Employer_____

Address_____ Phone_____

Preferred Phone (please circle) Home Cell Work E-mail Address_____

Name of Spouse_____

Employer_____Phone_____

Referring Dentist_____ Date of Last Visit_____

General Dentist (if different from referring dentist)_____

Medical Physician_____ Date of Last Physical Exam_____

Payment Method (circle) Cash Check Credit Card Insurance with Deposit

Name of **Dental Insurance Co.**:

Primary Insurance Co._____ ID#_____ Group#_____

Name of Policy Holder_____ Date of Birth_____

Employer for Insurance_____

Secondary Insurance Co._____ ID#_____ Group#_____

Name of Policy Holder_____ Date of Birth_____

Employer for Insurance_____

IF MINOR, Parents:

Mother_____Address_____

Phone _____ Employer_____

Father_____ Address_____

Phone_____ Employer_____

CONTINUED ON BACK

MEDICAL HISTORY

Are you currently undergoing medical treatment?	Yes	No
Have you been hospitalized or had surgery in the last two years?	Yes	No
Do you bleed or bruise easily?	Yes	No
Do you **always** require antibiotics prior to dental treatment? (prosthetic joint, heart condition)	Yes	No
Have you had previous endodontic (root canal) treatment?	Yes	No
Do you or have you ever taken diet medication (Fen-Phen or other)?	Yes	No
(Women) Are you pregnant? Due date _____	Yes	No
(Women) Do you take oral contraceptives?	Yes	No

WARNING: Antibiotics may decrease their effectiveness.

Do you take medications? Please list: _____

_____

Have you ever taken or are currently taking a bisphosphonate (e.g. Fosamax, Boniva, Actenol) for osteoporosis or certain cancer treatments?	Yes	No

ARE YOU ALLERGIC TO:

Penicillin	Yes	No
Other medications_____	Yes	No
Latex	Yes	No
Lidocaine or Carbocaine	Yes	No

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Please Circle

High/Low Blood Pressure	Heart Attack	Neurologic Disorders
Respiratory/Asthma	Stroke	Tumor/Neoplasms
Rheumatic Fever	Heart Arrhythmia	Alcoholism/Addiction
Immunocompromised	Angina	Hepatitis
Anemia/Bleeding	Pace Maker	A____ B____ or C____
Diabetes	Tuberculosis	Liver Disease
Thyroid/Hormonal	Ulcers/Digestive	Arthritis
Kidney	Migraines/Headaches	Steroid Therapy
Chemo/Radiation	Epilepsy/Fainting	Leukemia
By-pass Surgery	Glaucoma/Visual	AIDS/HIV

I have read and fully understand all of the information on this sheet._____