

720 Osterman Ave.
Deerfield, IL. 60015
(847) 945-1100
(847) 945-7000 Fax



Patient Information

Last Name: _____ **First Name:** _____ **Middle Initial:** _____ **Sex:** _____

Preferred Name: _____ **Date of Birth:** ____/____/____ **Social Security #:** _____

Phone Home: _____ **Cell:** _____

Email Address: _____

Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Employed by: _____ **Occupation:** _____ **Work Phone:** _____

Marital Status: Married _____ Single _____ Child _____ Other: _____

Spouse's Name: _____

Date of Birth: ____/____/____ **Social Security #:** _____

Employed by: _____ **Occupation:** _____ **Work Phone:** _____

Name of Person to Contact in case of Emergency: _____

Phone #: _____ **Relationship:** _____

Insurance Information

(Please provide your insurance card to the receptionist)

Primary Insurance

Company: _____

Address: _____

City: _____ **State:** _____ **Zip** _____

Insurance Telephone: _____

Policy / Group #: _____

Policy Holder's Name: _____

Relationship to Patient: _____

Secondary Insurance

Company: _____

Address: _____

City: _____ **State:** _____ **Zip** _____

Insurance Telephone: _____

Policy / Group #: _____

Policy Holder's Name: _____

Relationship to Patient: _____

Referral Information

How did you hear about us? _____ Dentist _____ Family _____ Friend _____ Doctor _____ Yellow Pages _____ Other

Name of person to thank for referral: _____

1. Is your general health good at this time? ___ Yes ___ No
2. Are you under the care of a physician at this time? ___ Yes ___ No
Explain: _____
3. Name of physician? _____
4. Are you taking any medication? ___ Yes ___ No
If yes, what _____
Are you taking aspirin or any blood thinners? ___ Yes ___ No
5. Are you allergic to any medication? (Penicillin, Sulfa, etc.) ___ Yes ___ No
If yes, what: _____
6. Have you ever had a serious illness or been hospitalized? ___ Yes ___ No
7. Do you have any special problems not listed? ___ Yes ___ No
Explain: _____
8. Have you ever been advised by your physician to take an antibiotic prior to any dental treatment? ___ Yes ___ No
If yes, antibiotic name and method: _____
9. WOMEN: Are you pregnant or considering pregnancy during the next 2 years? ___ Yes ___ No
Are you nursing? ___ Yes ___ No Are you currently taking medication for birth control ___ Yes ___ No
10. Do you wish to talk to the dentist privately about any problems? ___ Yes ___ No

11. Do you have now or have you ever had any of the following?

Yes	No		Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic (artificial) Joint	<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells
<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray/Radiation (cancer) Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or H.I.V. Positive	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction
<input type="checkbox"/>	<input type="checkbox"/>	Heart Angina	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Earaches
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Clicking
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type? _____)	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery date: _____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Metal
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Herpes (oral-cold sores)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems
<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders/Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Lung or Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems

Other: _____

I certify that the information given is correct.

Signature _____ Date _____

Reviewed by: _____ Date _____