Associates For Family Dentistry Chicago, LTD

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Patient Name: _____ Birth Date: _____/_____/_____

Name of Parents (if child) _____

Patient Social Security # _____ Email: _____

Patient Address: _____

City_____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Patient Employed By: _____

Business Address: _____ Phone: ( ) _____

Marital Status: Married _____ Divorced _____ Widowed _____ Single _____

Name of Spouse: _____ Social Security #_____

Primary Insurance Information

Name of Insured: _____Relationship to Patient: O Self O Spouse O Child O Other

Employer: _____ Employer Address: _____

Employer City, State & Zip: _____Policy Holder Birth Date: ____/____/____

Insurance Company: _____ Policy Holder Soc. Sec.# or ID#_____

Insurance Company Address: _____

Secondary Insurance Information

Name of Insured: _____Relationship to Patient: O Self O Spouse O Child O Other

Employer: _____ Employer Address: _____

Employer City, State & Zip: _____Policy Holder Birth Date: ____/____/____

Insurance Company: _____ Policy Holder Soc. Sec.# or ID#_____

Insurance Company Address: _____

Did someone refer you? O Yes O No If yes, please list name: _____

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MEDICAL HISTORY

PATIENT NAME: _____ BIRTH DATE: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is apart of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	O Yes O No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	O Yes O No	If yes, please explain: _____
Are you taking any mediations, pills, drugs?	O Yes O No	If yes, please explain:
Are you on a special diet?	O Yes O No	_____
Do you use tobacco?	O Yes O No	_____
Do you use controlled substances?	O Yes O No	

Women: Are You

Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?

☐Local Anesthetics ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐ Others_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	O Yes O No	Convulsions	O Yes O No	Herpes	O Yes O No	Scarlet Fever	O Yes O No
Alzheimer's Disease	O Yes O No	Cortisone Medicine	O Yes O No	High Blood Pressure	O Yes O No	Shingles	O Yes O No
Anaphylaxis	O Yes O No	Diabetes	O Yes O No	Hives or Rash	O Yes O No	Sickle Cell Disease	O Yes O No
Anemia	O Yes O No	Drug Addiction	O Yes O No	Hypoglycemia	O Yes O No	Sinus Trouble	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	Irregular Heartbeat	O Yes O No	Spina Bifida	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	Kidney Problems	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Leukemia	O Yes O No	Stroke	O Yes O No
Artificial Joint	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Liver Disease	O Yes O No	Swelling of Limbs	O Yes O No
Asthma	O Yes O No	Frequent Cough	O Yes O No	Low Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Blood Disease	O Yes O No	Frequent Headaches	O Yes O No	Lung Disease	O Yes O No	Tonsillitis	O Yes O No
Blood Transfusion	O Yes O No	Glaucoma	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tuberculosis	O Yes O No
Breathing Problem	O Yes O No	Hay Fever	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Bruise Easily	O Yes O No	Heart Attack/Failure	O Yes O No	Parkinson's Disease	O Yes O No	Ulcers	O Yes O No
Cancer	O Yes O No	Heart Murmur	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
Cerebral Palsy	O Yes O No	Heart Pace Maker	O Yes O No	Radiation Treatments	O Yes O No		
Chemotherapy	O Yes O No	Heart Trouble/Disease	O Yes O No	Recent Weight Loss	O Yes O No		
Chest Pains	O Yes O No	Hemophilia	O Yes O No	Renal Dialysis	O Yes O No		
Cold Sores/Fever Blisters	O Yes O No	Hepatitis A	O Yes O No	Rheumatic Fever	O Yes O No		
Congenital Heart Disorder	O Yes O No	Hepatitis B or C	O Yes O No	Rheumatism	O Yes O No		

Have you ever had any serious illness not listed above? O Yes O No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE: _____