



1401 S. Arlington Heights Rd. Suite One
Arlington Heights, Illinois 60005
847-259-7789

Patient Information

Name _____ Birthdate _____
Last First Middle

Resident Address _____
Street City Zip Phone

Employer _____ Occupation _____ No./yrs. _____

Address _____
Street City Zip Phone

Do you have dental insurance? Yes No Your Social Security No. _____

Marital Status: M W S D Name of Spouse _____

Spouse's Employer _____ No./yrs. _____

Address _____
Street City Zip Phone

Who is responsible for your account? _____ Social Security No. _____

Who referred you to our office? _____

Medical Information History

CIRCLE THE APPROPRIATE ANSWER. YOUR ANSWERS WILL BE CONFIDENTIAL.

Yes No Are you taking any medication, drugs or pills? If yes, what?
Yes No Are you presently in good health?
Yes No Have you been under a physician's care in the last 2 years?
Yes No Last Medical Exam _____ Name of Physician _____

ARE YOU ALLERGIC TO OR TOLD NOT TO TAKE:

Yes No Penicillin
Yes No Codeine
Yes No Others (Please specify) _____

HAVE YOU EVER BEEN TREATED FOR OR DO YOU HAVE:

Yes	No	Heart disease	Yes	No	Tuberculosis or lung disease
Yes	No	Rheumatic fever	Yes	No	Asthma or hay fever
Yes	No	High blood pressure	Yes	No	Allergies (including jewelry)
Yes	No	Shortness of breath	Yes	No	Persistent cough
Yes	No	Pain, pressure in chest	Yes	No	Epilepsy
Yes	No	Anemia	Yes	No	Fainting spells
Yes	No	Excessive bleeding	Yes	No	Sinus trouble
Yes	No	Heart murmur	Yes	No	Nervous problems
Yes	No	Mitral Valve Prolapse	Yes	No	Cancer
Yes	No	Stroke	Yes	No	Arthritis
Yes	No	Jaundice	Yes	No	Diabetes
Yes	No	Hepatitis	Yes	No	Ear problems
Yes	No	Glaucoma			
Yes	No	Ulcers			
Yes	No	A.I.D.S.			
Yes	No	Herpes			

FOR WOMEN:

Yes No Are you pregnant?
Due date? _____
Yes No Are you on birth control pills?

Yes No Do you have any other condition or disease that we should know about?