OAK PARK
DENTAL STUDIO

6630 W. Roosevelt Road, Oak Park, IL 60304
708-386-2233

## Patient Information

Last name: _____ First name: _____ Middle initial: _____

Address: _____

Home phone: _____ Work: _____ Cell: _____

email address: _____ Social Security Number: _____

Marital Status:_____ Date of Birth: _____

Drivers license number: _____ Other ID: _____

Employer: _____

Address: _____

Name of nearest relative not living with you: _____

Relationship: _____ Phone number: _____

**How did you hear about us?_____**

## Dental History

When was your last visit to the dentist? _____

What treatment was performed? _____

When was your last full mouth x-ray taken and where? _____

Do you at the present time have any dental concerns? _____

Have you ever had *Lidocaine* and have you ever had any allergic reactions? _____

Do you suffer from dry mouth? _____

## Insurance Information

Primary insurance carrier: _____

Phone: _____ Group Policy Number: _____

Name of insured: _____ Relationship to insured: _____

## Medical History

Name of primary care physician: _____ Phone:_____

Are you under medical treatment now? If so please explain. _____

_____

Please list any medications you are presently taking: _____

_____

What if any medications are you allergic to? _____

Do you have any disabilities that require special assistance? _____

Are you pregnant and or breast feeding? _____ Taking oral contraceptives? _____

Do you smoke? Yes____ No____ If yes, how much?_____

Do you have, or have you ever been informed by a physician of having any of the following…

- ❍ Alcohol Sensitivity
- ❍ Allergies
- ❍ Anemia
- ❍ Arthritis
- ❍ Artificial Joints
- ❍ Asthma
- ❍ Blood Disease
- ❍ Codeine Allergy
- ❍ Depression
- ❍ Diabetes
- ❍ Dizziness
- ❍ Drug Dependency
- ❍ Epilepsy
- ❍ Excessive Bleeding
- ❍ Fainting
- ❍ Glaucoma
- ❍ Growths
- ❍ Hay Fever
- ❍ Head Injuries
- ❍ Heart Disease
- ❍ Heart Murmur
- ❍ Hepatitis
- ❍ Herpes
- ❍ High Blood Pressure
- ❍ HIV
- ❍ Jaundice
- ❍ Kidney Disease
- ❍ Latex Allergies
- ❍ Liver Disease
- ❍ Mental Disorders
- ❍ Nervous Disorders
- ❍ Cancer
- ❍ Pacemaker
- ❍ Penicillin Allergy
- ❍ Pre-medication Need
- ❍ Radiation Treatment
- ❍ Respiratory Condition
- ❍ Rheumatic Fever
- ❍ Rheumatism
- ❍ Sinus Condition
- ❍ Stomach Condition
- ❍ Stroke
- ❍ Sulfa Drug Allergy
- ❍ Thyroid Condition
- ❍ Tuberculosis
- ❍ Tumors
- ❍ Ulcers
- ❍ Venereal Disease
- ❍ Other (Please explain) _____

_____ _____

Patient/Guardian Signature Date