MEDICAL - DENTAL HISTORY

PATIENT NAME ______________________________ BIRTHDATE ______________

PATIENT MEDICAL HISTORY CHECK YES OR NO

☐YES ☐NO Are you under any Medical treatment now?

☐YES ☐NO Have you had any major operations? If so, what? ______________

☐YES ☐NO Have you ever had a serious accident involving head or jaw injuries?

☐YES ☐NO Have you had any adverse response to any drugs including penicillin and aspirin?

☐YES ☐NO Have you ever had any of the following?

- ☐Heart Ailment
- ☐High Blood Pressure
- ☐Low Blood Pressure
- ☐Respiratory Disease
- ☐Diabetes
- ☐Rheumatic Fever
- ☐Rheumatism or Arthritis
- ☐Tumors or Growths
- ☐ Any Blood Disease
- ☐ Any Liver Disease
- ☐ Any Kidney Disease
- ☐ Any Stomach or Intestinal Disease
- ☐ Any Venereal Disease
- ☐ Yellow Jaundice or Hepatitis
- ☐ Epilepsy
- ☐ AIDS

☐YES ☐NO Are you on a diet at this time?

☐YES ☐NO Are you now taking drugs or medications?

☐YES ☐NO Are you allergic to any known materials resulting in - hives, asthma, eczema, etc?

☐YES ☐NO Do you have any reason to supect you are <u>not</u> in good health?

☐YES ☐NO Have any wounds healed slowly or presented other complications?

☐YES ☐NO Are you pregnant?

☐YES ☐NO Do you have a history of fainting?

☐YES ☐NO Have you ever been diagnosed with cancer?

☐YES ☐NO Have you ever had chemotherapy?

☐YES ☐NO Have you ever had radiation therapy?

☐YES ☐NO Have you received any donor organs, artificial heart valves, vessels, joint implants or use a pacemaker?

☐YES ☐NO Does your medical doctor recommend pre-medication before dental treatment?

CURRENT MEDICATION	REASON
List additional medications on reverse side	

PATIENT DENTAL HISTORY CHECK YES OR NO

☐YES ☐NO Do you have any specific problems?

☐YES ☐NO Do you have pain in or near your ears?

☐YES ☐NO Do you have any unhealed injuries or inflamed areas in or around your mouth?

☐YES ☐NO Have you experienced any growth or sore spots in your mouth?

☐YES ☐NO Does any part of your mouth hurt when clenched?

☐YES ☐NO Have you ever had Novocaine anesthetic?

☐YES ☐NO Any reactions or allergic symptoms to anesthetics?

☐YES ☐NO Any difficult extractions in the past?

☐YES ☐NO Have you had prolonged bleeding following extractions in the past?

☐YES ☐NO Do your gums bleed?

☐YES ☐NO Have you ever been instructed on the correct method of brushing your teeth?

☐YES ☐NO Have you ever been instructed on the care of your gums?

☐YES ☐NO Do you chew on only one side of your mouth?

☐YES ☐NO Do you habitually clench your teeth during the night or day?

☐YES ☐NO Have you had a full mouth X-RAY? If so, when? ______________ Where? ______________

☐YES ☐NO Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)? If so, locate ______________

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Signature ______________________ Date ____________

RECERTIFICATION: I certify that there have been no changes in my health except as noted below.

Date	Change	Signature

MEDICAL/DENTAL HISTORY

IDA-01

ILLINI DENTAL ASSOCIATES, P.C.
2909 19TH STREET
EAST MOLINE, IL 61244
309-796-2251

BRIAN BOLLAERT, D.D.S.
KORY MELIN, D.M.D.
JOHN FEEHAN, D.D.S.

Patient Information

Date ______________ Home Phone ____________________________ S.S. # ______________________________

Name ____ Preferred Name ____________________
Last First Initial

Address ____

City ________________________ State ______________________ Zip ________________________________

Sex ☐ Male ☐ Female Age _____ Birthdate __________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient employed by ____ Business Phone ________________

In case of an emergency who whould be notified ______________________________ Phone ________________

Referred By ____

Primary Insurance

Person responsible for account ____
Last First Initial

Relation to patient ______________________ Birthdate __________ S.S. # _____________________________

Address (if different from above) ____ Phone ________________

City ________________________ State ______________________ Zip ________________________________

Person responsible employed by _____________________________________ Business Phone ________________

Insurance company ____ Insurance Phone ________________

Address ____ Group # ______________

Name of other dependents covered under this plan ____

Additional Insurance

Is patient covered by additional Insurance? ☐ Yes ☐ No

Subscriber name ____ Relationship to patient ________________

Birthdate ____________________________________ S.S. # ____

Address (if different from patient) ____ Phone ________________

City ________________________ State ______________________ Zip ________________________________

Subscriber employed by ____ Business Phone ________________

Insurance company ____ Insurance Phone ________________

Address ____ Group # ______________

Name of other dependents covered under this plan ____

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____ Date ____________________________