South Barrington Dental Care
8 Executive Court, Suite 2
South Barrington, IL 60010

Medical History:

Full Name (include MI): _____ Date _____
Name of Medical Doctor: _____ City/State: _____
Emergency contact: _____ Relationship _____

List all medications that you are now taking:

_____ _____
_____ _____
_____ _____
_____ _____

Are you **allergic** to any of the following?

Y	N		Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine	☐	☐	Metal
☐	☐	Aspirin	☐	☐	Latex	☐	☐	Erythromycin
☐	☐	Codeine	☐	☐	Penicillin	*Please list any other allergies below:		
☐	☐	Ibuprofen	☐	☐	Sulfa	_____		

Do you have any of the following **medical conditions**?

Y	N		Y	N		Y	N	
☐	☐	Asthma/Breathing Issues	☐	☐	Kidney Disease	☐	☐	Hepatitis
☐	☐	Bleeding problems	☐	☐	Liver Disease	☐	☐	HIV+/AIDS
☐	☐	Cancer	☐	☐	Osteoporosis	☐	☐	Lupus
☐	☐	Diabetes	☐	☐	Pregnancy	☐	☐	Persistent Cough
☐	☐	Heart Murmur	☐	☐	Psychiatric Treatment	☐	☐	Thyroid Problems
☐	☐	Heart Trouble	☐	☐	Sinus Trouble	☐	☐	Tuberculosis (TB)
☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐	Seizures
☐	☐	Joint Replacement	☐	☐	Ulcers			
☐	☐	Rheumatic Fever	☐	☐	Blood Disorders			
☐	☐	Fainting spells	☐	☐	History of Drug/Alcohol abuse			

*Please list any other medical conditions not listed above:

_____
_____
_____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit _____ Are you in pain? _____

New patients:

Do you have a panoramic x-ray of full mouth x-rays that are less than 5 years old?_____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

For Women:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No ☐ Unsure

*If yes, week # _____

Are you nursing ? ☐ Yes ☐ No

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand this information on this form is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

_____ _____

Patient/Guardian Signature Date

_____ _____

Dentist Signature Date