Lincoln Park Cosmetic Dentists

Patient Information Form

Dr. Szurgot
2551 N Clark St # 700 Chicago, IL 60614
(773) 669-4200
http://www.lincolnparkcosmeticdentists.com/

Date:

Name:

Address:

City: State: Zip Code:

Home phone #: Work: Cell:

E-mail address:

Birthdate: Marital status: Social security #

Spouse: Birthdate:

Employer:

Address:

City: State: Zip Code:

Occupation:

Person responsible financially: Who referred you to our office?

Dental insurance carrier:

Address:

City: State: Zip Code: Phone #

Subscriber name and SS#:

Group/policy #: I also have secondary coverage: ◯Yes ◯No

Person to contact for emergencies:

Relationship to you: Phone #:

Health History

Name: ____________________

- I am having pain/discomfort at this time ◯ Yes ◯ No
- I am feeling very nervous about having dental treatment ◯ Yes ◯ No
- I have previously had a bad experience in a dental office ◯ Yes ◯ No
- I have been a patient in the hospital during the past two years. ◯ Yes ◯ No
- I have been under the care of a physician during the past two years. ◯ Yes ◯ No

  Physician's name and phone # ____________________
- I have taken prescription drugs during the past two years. ◯ Yes ◯ No
- I am now taking prescription or non-prescription medication ◯ Yes ◯ No

  List: ____________________
- **I am allergic to one or more of the following medications (please check)**

  ☐ Aspirin ☐ Nitrous Oxide ☐ Vallum ☐ Penicillin ☐ Darvon ☐ Earythromycin (Local anesthetic)

  ☐ Scopolarnine ☐ Codeine ☐ Tetracycline ☐ Novacaine ☐ Xylocaine

  ☐ Demerol ☐ Percodin ☐ Nembutal ☐ Seconal ☐ Tylenol ☐ Advil ☐ Alleve
- I am allergic to other medication or substances ◯ Yes ◯ No

  List: ____________________

- I had or have at present one or more of the following (please check):

  ☐ Hearth Failure ☐ Emphysema ☐ Heart Murmur ☐ Hay Fever ☐ Jaundice

  ☐ Rheumatic Fever ☐ A.I.D.S. ☐ Searlet Fever ☐ Sinusitis ☐ Asthma

  ☐ Blood Transfusion ☐ H.I.V. ☐ Diabetes ☐ Hemophilia ☐ Epilepsy

  ☐ Drug Addition ☐ Heart Attack ☐ Chemotherapy ☐ Arthritis ☐ Anemia

  ☐ Psychiatric Treatment ☐ Heart Disease ☐ Hrt. Pacemaker ☐ Cold Sores ☐ S.T.D.

  ☐ Artificial Hrt, Valve ☐ Hepatitis A ☐ Glaucoma ☐ Ulcers ☐ Nervousness

  ☐ Fainting Spells ☐ Hepatitis B ☐ Artificial Hip/Knee ☐ Rheumatism ☐ Kidney Failure

  ☐ Cortisone Treatment ☐ Angina ☐ Cerebral Palsy ☐ Leukemia ☐ Tuberculosis

  ☐ Liver Disease ☐ High Blood Pressure ☐ Multiple Sclerosis ☐ Bruising ☐ Alcoholism

  ☐ Cosmetic Surgery ☐ M.R.I. ☐ Neurotic Disorder ☐ Cong. Heart Lesions

- I had or have at present other conditions ◯ Yes ◯ No

  List: ____________________
- I have chest pain or shortness of breath when I walk up stairs or long distances ◯ Yes ◯ No
- My ankles swell during the day. ◯ Yes ◯ No
- I use more than 2 pillows to sleep ◯ Yes ◯ No
- I have gained or lost more than 10 pounds during the past year. ◯ Yes ◯ No
- I am on a special diet per my physician ◯ Yes ◯ No
- My physician has told me I have cancer or a tumor ◯ Yes ◯ No
- I am currently pregnant. ◯ Yes ◯ No

  If yes, what month are you in: ____________

I hereby certify that the above information is true to the best of my knowledge. I also authorize the dentist or designated staff to take any x-rays, study models, photos or other diagnostic aids deemed necessary in relation to the maintenance of my oral health. I also understand that i am responsible for all balances incurred regardless of any insurance benefits payable to myself or the dentist.

____________________ ____________________

Signature (Patient or Responsible Party) Date