

# Associates For Family Dentistry Chicago, LTD

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Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Parents (if child) \_\_\_\_\_

Patient Social Security # \_\_\_\_\_ Email: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Patient Employed By: \_\_\_\_\_

Business Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Social Security # \_\_\_\_\_

## **Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Child  Other

Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Employer City, State & Zip: \_\_\_\_\_ Policy Holder Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Holder Soc. Sec.# or ID# \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

## **Secondary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Child  Other

Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Employer City, State & Zip: \_\_\_\_\_ Policy Holder Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Holder Soc. Sec.# or ID# \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Did someone refer you?  Yes  No If yes, please list name: \_\_\_\_\_

**MEDICAL HISTORY**

PATIENT NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is apart of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- |   |            |                               |
|---|------------|-------------------------------|
| Are you under a physician's care now?                     | O Yes O No | If yes, please explain: _____ |
| Have you ever been hospitalized or had a major operation? | O Yes O No | If yes, please explain: _____ |
| Have you ever had a serious head or neck injury?          | O Yes O No | If yes, please explain: _____ |
| Are you taking any medications, pills, drugs?             | O Yes O No | If yes, please explain: _____ |
| Are you on a special diet?                                | O Yes O No | _____                         |
| Do you use tobacco?                                       | O Yes O No | _____                         |
| Do you use controlled substances?                         | O Yes O No | _____                         |

**Women: Are You**

Pregnant/Trying to get pregnant? O Yes O No      Taking oral contraceptives? O Yes O No      Nursing? O Yes O No

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

Local Anesthetics     Aspirin     Penicillin     Codeine     Acrylic     Metal     Latex     Others \_\_\_\_\_

**Do you have, or have you had, any of the following?**

- |                           |            |                           |            |                       |            |                            |            |
|---------------------------|------------|---------------------------|------------|-----------------------|------------|----------------------------|------------|
| AIDS/HIV Positive         | O Yes O No | Convulsions               | O Yes O No | Herpes                | O Yes O No | Scarlet Fever              | O Yes O No |
| Alzheimer's Disease       | O Yes O No | Cortisone Medicine        | O Yes O No | High Blood Pressure   | O Yes O No | Shingles                   | O Yes O No |
| Anaphylaxis               | O Yes O No | Diabetes                  | O Yes O No | Hives or Rash         | O Yes O No | Sickle Cell Disease        | O Yes O No |
| Anemia                    | O Yes O No | Drug Addiction            | O Yes O No | Hypoglycemia          | O Yes O No | Sinus Trouble              | O Yes O No |
| Angina                    | O Yes O No | Emphysema                 | O Yes O No | Irregular Heartbeat   | O Yes O No | Spina Bifida               | O Yes O No |
| Arthritis/Gout            | O Yes O No | Epilepsy or Seizures      | O Yes O No | Kidney Problems       | O Yes O No | Stomach/Intestinal Disease | O Yes O No |
| Artificial Heart Valve    | O Yes O No | Excessive Bleeding        | O Yes O No | Leukemia              | O Yes O No | Stroke                     | O Yes O No |
| Artificial Joint          | O Yes O No | Fainting Spells/Dizziness | O Yes O No | Liver Disease         | O Yes O No | Swelling of Limbs          | O Yes O No |
| Asthma                    | O Yes O No | Frequent Cough            | O Yes O No | Low Blood Pressure    | O Yes O No | Thyroid Disease            | O Yes O No |
| Blood Disease             | O Yes O No | Frequent Headaches        | O Yes O No | Lung Disease          | O Yes O No | Tonsillitis                | O Yes O No |
| Blood Transfusion         | O Yes O No | Glaucoma                  | O Yes O No | Mitral Valve Prolapse | O Yes O No | Tuberculosis               | O Yes O No |
| Breathing Problem         | O Yes O No | Hay Fever                 | O Yes O No | Pain in Jaw Joints    | O Yes O No | Tumors or Growths          | O Yes O No |
| Bruise Easily             | O Yes O No | Heart Attack/Failure      | O Yes O No | Parkinson's Disease   | O Yes O No | Ulcers                     | O Yes O No |
| Cancer                    | O Yes O No | Heart Murmur              | O Yes O No | Psychiatric Care      | O Yes O No | Venereal Disease           | O Yes O No |
| Cerebral Palsy            | O Yes O No | Heart Pace Maker          | O Yes O No | Radiation Treatments  | O Yes O No |                            |            |
| Chemotherapy              | O Yes O No | Heart Trouble/Disease     | O Yes O No | Recent Weight Loss    | O Yes O No |                            |            |
| Chest Pains               | O Yes O No | Hemophilia                | O Yes O No | Renal Dialysis        | O Yes O No |                            |            |
| Cold Sores/Fever Blisters | O Yes O No | Hepatitis A               | O Yes O No | Rheumatic Fever       | O Yes O No |                            |            |
| Congenital Heart Disorder | O Yes O No | Hepatitis B or C          | O Yes O No | Rheumatism            | O Yes O No |                            |            |

Have you ever had any serious illness not listed above? O Yes O No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

\_\_\_\_\_ DATE: \_\_\_\_\_