ADG | AURORA DENTAL GROUP
We Make You Smile.

1352 W. Galena Boulevard, Aurora, IL 60506
P: 630.896.7354 **F:** 630.896.7480
www.AuroraDentalGroup.com

Medical History

For : _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part 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?	○ Y ○ N	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	○ Y ○ N	If yes, please explain: _____
Have you ever had a serious head or neck injury?	○ Y ○ N	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	○ Y ○ N	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	○ Y ○ N	If yes, please explain: _____
Do you take, or have you taken Bisphosphonates (ie. Boniva, Fosamax)?	○ Y ○ N	If yes, please explain: _____
Are you on a special diet?	○ Y ○ N	_____
Do you use tobacco?	○ Y ○ N	_____
Do you use controlled substances?	○ Y ○ N	

Women, are you:

Pregnant/Trying to get pregnant? ○Y ○N Taking Oral Contraceptives? ○Y ○N Nursing? ○Y ○N

Are you allergic to any of the following:

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other (If yes, please explain:) _____

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

AIDS/HIV Positive ○ Y ○ N	Cortisone Medicine ○ Y ○ N	Hemophilia ○ Y ○ N	Renal Dialysis ○ Y ○ N
Alzheimer's Disease ○ Y ○ N	Diabetes ○ Y ○ N	Hepatitis A ○ Y ○ N	Rheumatic Fever ○ Y ○ N
Anaphylaxis ○ Y ○ N	Drug Addiclion ○ Y ○ N	Hepatitis B or C ○ Y ○ N	Rheumatism ○ Y ○ N
Anemia ○ Y ○ N	Easily Winded ○ Y ○ N	Herpes ○ Y ○ N	Scarlet Fever ○ Y ○ N
Angina ○ Y ○ N	Emphysema ○ Y ○ N	High Blood Pressure ○ Y ○ N	Shingles ○ Y ○ N
Arthritis/Gout ○ Y ○ N	Epilepsy or Seizures ○ Y ○ N	Hives or Rash ○ Y ○ N	Sickle Cell Disease ○ Y ○ N
Artificial Heart Valve ○ Y ○ N	Excessive Bleeding ○ Y ○ N	Hypoglycemia ○ Y ○ N	Sinus Trouble ○ Y ○ N
Artificial Joint ○ Y ○ N	Excessive Thirst ○ Y ○ N	Irregular Heartbeat ○ Y ○ N	Spina Bifida ○ Y ○ N
Asthma ○ Y ○ N	Fainting Spells/Dizziness ○ Y ○ N	Kidney Problems ○ Y ○ N	Stomach/Intestinal Disease ○ Y ○ N
Blood Disease ○ Y ○ N	Frequent Cough ○ Y ○ N	Leukemia ○ Y ○ N	Stroke ○ Y ○ N
Blood Transfusion ○ Y ○ N	Frequent Diarrhea ○ Y ○ N	Liver Disease ○ Y ○ N	Swelling of Limbs ○ Y ○ N
Breathing Problem ○ Y ○ N	Frequent Headaches ○ Y ○ N	Low Blood Pressure ○ Y ○ N	Thyroid Disease ○ Y ○ N
Bruise easily ○ Y ○ N	Genital Herpes ○ Y ○ N	Lung Disease ○ Y ○ N	Tonsillitis ○ Y ○ N
Cancer ○ Y ○ N	Glaucoma ○ Y ○ N	Mitral Valve Prolapse ○ Y ○ N	Tuberculosis ○ Y ○ N
Chemotherapy ○ Y ○ N	Hay Fever ○ Y ○ N	Pain in Jaw Joints ○ Y ○ N	Tumors or Growths ○ Y ○ N
Chest Pains ○ Y ○ N	Heart Attack/Failure ○ Y ○ N	Prathyroid Disease ○ Y ○ N	Ulcers ○ Y ○ N
Cold Sores/Fever Blisters ○ Y ○ N	Heart Murmur ○ Y ○ N	Psychiatric Care ○ Y ○ N	Venereal Disease ○ Y ○ N
Congenital Heart Disorder ○ Y ○ N	Heart Pace Maker ○ Y ○ N	Radiation Treatments ○ Y ○ N	Yellow Jaundice ○ Y ○ N
Convulsions ○ Y ○ N	Heart Trouble/Disease ○ Y ○ N	Recent Weight Loss ○ Y ○ N	

Have you ever had any serious illness not listed above? ○Y ○N 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 the medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ DATE:_____

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ABOUT YOU

Today's Date: _____

Social Security #: _____

Name: _____
LAST FIRST MIDDLE INITIAL

I like to be called: _____

Home Address : _____

_____
APT # CITY STATE ZIP

Mailing Address, If Different:

Address: _____

_____
APT # CITY STATE ZIP

Your Employer: _____

Occupation:_____ How long held:_____

Birthday: _____/_____/_____ ◯ Male ◯ Female

◯ Single ◯ Married ◯ Divorced ◯ Widowed

Special interests, sports or hobbies: _____

_____

Referred by: _____

RESPONSIBLE PARTY

Name: _____ Re!ationship: _____

Address: _____

Home Phone # _____ Work Phone # _____

CONTACT INFO

Home Phone: _____

Work Phone: _____ Ext. #: _____

Cell Phone: _____ _____

Email Address: _____

In the event of an emergency, is there someone who lives near you that we could contact?

Name: _____ Relationship: _____

Work #: _____ Home #: _____

INSURANCE INFORMATION

PLEASE COMPLETE IF YOU HAVE DENTAL INSURANCE

Primary Insurance Co. Name: _____

Insurance Company's Address: _____

City, Stale. Zip _____

Insured's ID # _____ Group Plan # _____

PLEASE COMPLETE IF YOU HAVE ADDITIONAL DENTAL INSURANCE

Secondary Insurance Co. Name: _____

Insurance Company's Address: _____

City, Stale. Zip _____

Insured's ID # _____ Group Plan # _____

POLICYHOLDER INFORMATION

Complete the information below if PATIENT is NOT the POLICYHOLDER

Primary Policyholder's Name _____

Primary Policyholder's Address _____

City. State, Zip _____

Telephone _____

Birthday: _____/_____/_____ ◯ Male ◯ Female

Employer's Name or School Name _____

Employer's Phone _____

Employer's Address _____

City, State, Zip _____

Social Security #: _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other _____

Employer Plan Coverage: ☐ Yes ☐ No

If Champus: ☐ Active ☐ Retired ☐ Deceased

Branch of Service: _____

RELEASE INFORMATION

I authorize the release of any dental information necessary to process by claim.

Signature: _____

AUTHORIZATION PAYMENT TERMS

I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment and that if I default in any way as to the payment of said costs, then I agree to pay all costs of collection including reasonable attorney's fees. I hereby authorize the Dental Office to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

_____ _____
Signature of responsible party State driver's license number