ORLAND DENTAL CENTER

9661 W. 143rd St Orland Park IL 60462
(708) 403-0100

PLEASE PRINT CLEARLY DATE:

Patient Name
Address
Phone Home ☐ Cell ☐ Age DOB Sex Weight SSN
Employer Work Phone Occupation
Spouses Name Employer Work Phone
Person Responsible for all fees if other than yourself
Address
Patients Physician

Health History

Please Check the appropriate Answer

1. Are you under the care of a physician? If yes, why?	Yes ☐	No ☐
2. Are you taking any drugs or medications now? If yes, what and dosage?	Yes ☐	No ☐
3. Have you ever had a serious illness? If yes, what?	Yes ☐	No ☐
4. Do you have shortness of breath, limitation of activity or swelling in your ankles?	Yes ☐	No ☐
5. Do you smoke or use tobacco?	Yes ☐	No ☐
6. Are you allergic or sensitive to any medications? (like penicillin, aspirin)	Yes ☐	No ☐

If yes to allergic, what?

7. Do you have or have you ever had: (Check all that apply)

Congenital heart disease	☐ Rheumatic fever	Anemia: easy bruising	Dizziness or fainting ☐
Heart attack or Heart failure	☐ Hepatitis, Jaundice, Liver disease	☐ Diabetes	Chronic cough:Bronchitis ☐
Heart surgery	☐ Hypertension (High blood pressure)	☐ Cancer	Tuberculosis:Pneumonia ☐
Heart murmur	☐ Mononucleosis	☐ Syphilis	Asthma:Hay Fever ☐
Mitral Valve Prolapse	☐ Epilepsy or seizures	☐ AIDS	Emphysema:lung disease ☐
Angina (Chest Pain)	☐ Stroke	☐ Hives or Skin rash	Kidney or Bladder disease ☐

8. HAVE YOU EVER TAKEN OR ARE YOU TAKING ANY OF THE FOLLOWING DRUGS? (Check if yes)

Digitalis:Diuretics	☐ High Blood Pressure medication	☐
Anticoagulants (blood thinners:Coumadin)	☐ Insulin or Diabetic medication	☐
Nitroglycerine	☐ Tranquilizers:Antidepressants	☐
Cortisone(Steroids)	☐ Birth Control pills	☐

9. Do you wear Contact lenses?	Yes ☐	No ☐
10. Do you presently have a cold, cough or bronchitis?	Yes ☐	No ☐
11. Have you had excessive bleeding following an extraction, cut or surgery?	Yes ☐	No ☐
12. Have you had an unfavorable reaction to local or general anesthesia?	Yes ☐	No ☐
13. Have you had any operations or hospitalizations in the past 5 years?	Yes ☐	No ☐
14. If patient is female, are you pregnant?	Yes ☐	No ☐
15. Have you ever had a radiation treatment for Tumor, Growth, or Disease?	Yes ☐	No ☐
16. Do you have any nasal obstruction or difficulty breathing through your nose?	Yes ☐	No ☐
17. Do you have any diseases, condition or problem not listed above?	Yes ☐	No ☐
18. For oral surgery do you prefer to go to sleep or to have local anesthesia?	Yes ☐	No ☐

THIS IS MY CONSENT FOR WILLIAM A. SEPER D.D.S., P.C. AND/OR ANY ASSOCIATE AND ASSISTANT WORKING WITH HIM TO PERFORM WHATEVER PROCEDURE/SURGERY AS DEEMED NECESSARY OR ADVISABLE AND TO THE ADMINISTRATION OF ANESTHESIA, INCLUDING LOCAL, INTRAVENOUS SEDATIVES AND/OR GENERAL ANESTHESIA IN CONNECTION WITH THE PROCEDURE(S)DEEMED ADVISABLE. I ALSO CERTIFY THAT I HAVE NOT WITHHELD ANY INFORMATION CONCERNING MY MEDICAL HISTORY OR HEALTH.

Signature: _____ Date:

If minor, the policy in our office is the parent who is request treatment for the child is responsible for all fees-for services rendered:

_____

Signature of Parent or Guardian requesting care

If you answered YES to any of the above, please indiacte the number and brief explanation: