Prairie Dental, Ltd.

23909 W. Renwick Rd.

Plainfield, IL 60586

Patient Information

Date_____

Patient_____

E-Mail_____

Address_____

_____

City_____State____Zip Code_____

Home Phone_____

Cell Phone_____

Work Phone_____

Sex □ Male □ Female Age_____Date of Birth_____

□ Single □ Married □ Divorced □ Separated

Occupation_____

Social Security Number_____

Spouse's Name_____

Spouse's Occupation_____

Spouse's Social Security Number _____

Whom may we thank for referring you?

_____

EMERGENCY CONTACT

(Specify someone who does not live in your household)

Name_____

Phone Number_____

Dental Insurance

Subscriber's Name

_____

Date of Birth_____

Relationship to Patient

□ Self □ Spouse □ Parent □ Legal Guardian

Insurance Company

_____

Group #_____

Employer_____

Address_____

Is patient covered by additional insurance □Yes □ No

Subscriber's Name

_____

Date of Birth_____

Insurance Company

_____

Group #_____

Employer_____

Address_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____and assign directly to **P. Lukawski, D.D.S.** all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

_____

Date_____

Relationship □ Self □ Spouse □ Parent □ Legal Guardian

ALLERGIES

□ No Known Allergies	□ Anesthesia	□ Sulfa
□ Aspirin	□ Ibuprofen	□ Household Bleach
□ Codeine	□ Clindamycin	□ Iodine
□ Latex	□ Erythromycin	□ Mouth Rinse
□ Penicillin	□ Tetracycline	□ Other_____

MEDICATIONS

List all medications, Vitamins, Herbs, Supplements, and Over-the-counter medications you are currently taking.

_____

Do you PRE MEDICATE before a dental procedure? If Yes, Why?_____

DENTAL HISTORY Place a mark "Yes" or "No" to indicate if you have had any of the following:

Dry mouth	Yes	No	History of periodontal disease	Yes	No
Grinding teeth	Yes	No	Sensitive teeth	Yes	No
Gums, swollen or bleeding	Yes	No	Sores or growth in your mouth	Yes	No
Loose teeth or broken fillings	Yes	No	Cigarette, pipe, or cigar smoking	Yes	No
Mouth breathing	Yes	No	Orthodontic treatment	Yes	No

Date of last dental exam_____ **Name last dentist**_____ **Last x-rays**_____

Place a mark "Yes" or "No" to indicate if you have had any of the following:

Artificial Heart Valves.....□Yes □ No
Date Placed_____
Artificial joints.....□ Yes □ No
Congenital Heart Lesion.....□ Yes □ No
Heart Murmur.....□ Yes □ No
Heart problems.....□ Yes □ No
High Blood Pressure.....□ Yes □ No
Low Blood Pressure.....□ Yes □ No
Mitral Valve Prolapse.....□ Yes □ No
Pacemaker.....□ Yes □ No
Date Placed_____
Shortness of Breath..... □ Yes □ No
Stroke.....□ Yes □ No
Stent.....□ Yes □ No
Date Placed_____
AIDS.....□ Yes □ No
Anemia.....□ Yes □ No
Arthritis.....□ Yes □ No
Asthma.....□ Yes □ No
Back problems.....□ Yes □ No
Hemophilia.....□ Yes □ No
Blood disease.....□ Yes □ No

Blood transfusion..... ...□ Yes □ No
Cancer.....□ Yes □ No
Cerebral Palsy.....□ Yes □ No
Chemotherapy.....□ Yes □ No
Circulatory problems.....□ Yes □ No
Cortisone treatment.....□ Yes □ No
Cough, persistent.....□ Yes □ No
Diabetes.....□ Yes □ No
Blood sugar level_____
Drug use.....□ Yes □ No
Emphysema.....□ Yes □ No
Epilepsy.....□ Yes □ No
Fainting or dizziness.....□ Yes □ No
Glaucoma.....□ Yes □ No
Headaches.....□ Yes □ No
Hepatitis.....Type_____□ Yes □ No
Herpes.....□ Yes □ No
HIV positive.....□ Yes □ No
Jaundice.....□ Yes □ No
Please list any conditions or illnesses not mentioned _____
_____

Nervous problems.....□ Yes □ No
Psychiatric care.....□ Yes □ No
Radiation treatment.....□ Yes □ No
Respiratory disease.....□ Yes □ No
Scarlet Fever.....□ Yes □ No
Sinus trouble.....□ Yes □ No
Skin Rash.....□ Yes □ No
Special diet.....□ Yes □ No
Swollen neck glands.....□ Yes □ No
Thyroid problems.....□ Yes □ No
Tonsillitis.....□ Yes □ No
Tuberculosis.....□ Yes □ No
Tumor of head/neck.....□ Yes □ No
Ulcer.....□ Yes □ No
Venereal disease.....□ Yes □ No
Weight loss, unexplained.....□ Yes □ No

FOR WOMEN ONLY:
Are you pregnant? ..... □ Yes □ No
Due Date_____
Is there a possibility of pregnancy?
□ Yes □No
Nursing? □ Yes □ No