Nancy A. Bagel, D.D.S., P.C.
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(847) 934-1177

Patient Name: _____ Date: _____
Last First MI

□ Male □ Female □ Married □ Single □ Child □ Other _____ Social Security # _____

Birth Date: _____ Drivers License: _____ e-mail address: _____

Phone: Home:_____ Work: _____ Cell: _____

Are there any restrictions on where we can contact you? _____

Address: _____
Street

_____
City State Zip Code

Welcome! *So that we may provide you with the best possible care*
please complete both sides of this medical/dental history form.
All information is completely confidential.

Medical Information:

Do you have, or have you ever had, any of the following? Please check those that apply:

□ Allergies
□ Codeine
□ Penicillin
□ Other
_____
□ Angina/Chest Pain
□ Anemia
□ Arthritis
□ Artificial Joints
_____
□ Artificial Valves
□ Asthma
□ Blood Disease
□ Blood Transfusion
□ Bruise Easily
□ Cancer
Type: _____
□ Chemotherapy
□ Chronic Cough
□ Cold Sores/ Fever Blisters
□ Congenital Heart Disease
□ Contact Lenses
□ Cortisone Medicine
□ Diabetes
□ Diet (Special/ Restricted)
□ Dizziness
□ Emphysema
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Hay Fever
□ Head Injuries
□ Heart Condition
□ Heart Disease
□ Heart Murmur
□ Hemophilia
□ Hepatitis A, B, or C (please circle)
□ High Blood Pressure
□ HIV/AIDS
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Mental/Nervous Disorders
□ Mitral Valve Prolapse
□ Pacemaker
□ Pregnant
When: _____
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Rheumatism
□ Sickle Cell Anemia
□ Sinus Problem
□ Stomach Problems
□ Stroke
□ Swollen Ankles
□ Thyroid Problems
□ Tuberculosis
□ Tumors/Growth
□ Ulcers
□ Venereal Disease
□ Other
_____
_____
_____

List any medications you are taking (ie. Birth control, vitamins, etc.) _____

_____

Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No

If yes, please explain: _____

Are you now under the care of a physician? □ Yes □ No

If yes, please explain: _____

Name of Physician: _____ Phone : _____

Do you use more than two pillows to sleep? □ Yes □ No

Have you lost or gained more than 10 pounds in the past year? □ Yes □ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

Emergency Information

Name and Address of nearest relative not living with you:

Name: _____ Relationship:_____ Phone: _____

Address: _____