LINCOLN PARK
INSTITUTE
FOR ORAL, FACIAL AND COSMETIC SURGERY

PATIENT INFORMATION

Date :

Name : Social Security # :

Address :

City : State : Zip :

Home Phone : Cell Phone : Drivers License # :

Email Address :

Sex : ☐ M ☐ F Date of Birth : Age : ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by : Occupation :

Business Address : Business Phone :

Emergency Contact : Phone :

Reason for today's visit : Referred by :

Dentist's Name : Address :

MEDICAL INFORMATION

Physicians Name : Date of last visit :

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe :

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date(s) :

Women : Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Please check Yes or No if you have, or had, any of the following conditions :

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Cortisone Treatments	☐	☐	HIV Positive	☐	☐	Scarlet Fever
☐	☐	Anemia	☐	☐	Cough, Persistent	☐	☐	Jaw Pain	☐	☐	Shortness of Breath
☐	☐	Arthritis, Rheumatism	☐	☐	Cough Up Blood	☐	☐	Joint Replacement	☐	☐	Skin Rash
☐	☐	Artificial Heart Valves	☐	☐	Diabetes			Date :	☐	☐	Stroke
☐	☐	Artificial Joints	☐	☐	Epilepsy			☐ Knee ☐ Hip ☐ Other	☐	☐	Swelling of Feet or Ankles
☐	☐	Asthma	☐	☐	Fainting	☐	☐	Kidney Disease	☐	☐	Thyroid Problems
☐	☐	Back Problems	☐	☐	Glaucoma	☐	☐	Liver Disease	☐	☐	Tobacco Habit
☐	☐	Bisphosphonate Therapy	☐	☐	Headaches	☐	☐	Mitral Valve Problems	☐	☐	Tonsillitis
		☐ Oral ☐ IV	☐	☐	Heart Murmur	☐	☐	Nervous Problems	☐	☐	Tuberculosis
☐	☐	Blood Disease	☐	☐	Heart Problems	☐	☐	Pacemaker	☐	☐	Ulcer
☐	☐	Cancer	☐	☐	Hemophilia	☐	☐	Psychiatric Care	☐	☐	Venereal Disease
☐	☐	Chemical Dependency	☐	☐	Hepatitis A	☐	☐	Radiation Treatment			
☐	☐	Chemotherapy	☐	☐	Hepatitis B or C	☐	☐	Respiratory Disease			
☐	☐	Circulatory Problems	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever			

List all medications you are currently taking :

List any known allergies :

INSURANCE AND PAYMENT INFORMATION

Person Responsible for Account :

Relationship to Patient : Date of Birth : Social Security # :

Address (if different than patient's) :

City : State : Zip :

Home Phone : Email Address :

Person Responsible Employed by : Occupation :

Business Address : Business Phone :

Insurance Company : ☐ Medical ☐ Dental

Contract # : Group # : Subscriber # :

Insurance Company's Address : Phone :

Is the patient covered by additional insurance? ☐ Yes ☐ No

Major Credit Card : ☐ MC ☐ VISA ☐ AMEX Credit Card Number : Exp. Date :

Major Credit Card : ☐ MC ☐ VISA ☐ AMEX Credit Card Number : Exp. Date :

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Patient/Legal Guardian Signature : Date :

I acknowledge that I have received information on the education and training of the doctors.

Patient/Legal Guardian Signature : Date :