



Medical History

116 North Locust Street
Mokenca, IL 60954
(815) 472-6345

www.ShanahanCheungDDS.com

Patient Information

Date _____ Home Phone _____

Cell Phone _____ Soc. Sec. _____ - _____ - _____

Name _____ Email _____
(Last) (First) (Middle Initial)

Address _____

City _____ State _____ Zip Code _____

Sex: Male Female Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Whom May We Thank for Referring You? _____

In Case of Emergency Who Should be Notified? _____

Contact Phone # _____ Cell Phone _____

Who is responsible for this account? _____

Dental History for NEW Patients

Reason for Todays Visit _____ Date of Last Dental Care _____

Former Dentist _____ Date of Last Dental X-Rays _____

Check If You Have Had problems with any of the following:

- Bad Breath Grinding Teeth Sensitivity to hot/cold/sweets Bleeding Gums
 Loose teeth/Broken fillings Clicking/popping of jaw Periodontal Treatment
 Sensitivity when biting Food Collection between teeth Sores/Growths in mouth None Apply

How Often Do You Floss? _____ How Often Do You Brush? _____

Medical History

Primary Physician Name _____ Date of Last Visit _____

Address _____

Specialist Name _____ Date of Last Visit _____

Address _____

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 medications that you are taking, could have an important interrelationship with the dentistry you will receive.

Have you ever had any serious illness/operations, been hospitalized ? Yes please describe & state when:

_____.

No

Have you ever had a blood transfusion? Yes Date(s) _____ No

Have you ever had a serious head or neck injury? Yes please describe _____ No

Do you take, have you taken; Phen-Fed/ Redux, Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Do you use any controlled substances? Yes please describe _____ No

Are you on a special diet? Yes No

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Are you allergic to any of the following? Please check all that apply:

- Aspirin Penicillin Codeine Acrylic Metals Latex Sulfa Drugs
- Local Anesthetics Please list any other allergies: _____

Authorization

I understand that the information that I have given today is correct to the best of my knowledge. I have received this practice's Notice of Privacy Practices. I give my permission to Ching Dental and staff to take clinical records and/or photographs of my dental treatment for educational and instructional purposes. We ask you to show consideration by calling in advance if you are unable to keep an appointment as we would like to have the option to offer that appointment to another patient, kindly give a 24 hour Notice or a \$50 cancellation fee will be billed directly to you. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at **time of treatment** unless prior arrangements have been approved