Brian P. Danielewicz, D.D.S.
424 Lake Street, Antioch, IL 60002 (847) 838-9944
740 Florsheim Drive, Libertyville, IL 60048 (847) 816-3377

OTHER INFORMATION

How did you hear about us?_____

What was the reason for today's visit?_____

Do you love your smile?_____

Is there anything you would like to change?_____

Why did you leave your last dentist?_____

What did you like most about your last dentist?_____

MEDICAL HISTORY AND INFORMATION

Conditions

- ❒ Abnormal Bleeding
- ❒ Alcohol Abuse
- ❒ Allergies
- ❒ Anemia
- ❒ Angina Pectoris
- ❒ Arthritis
- ❒ Artificial Heart Valve
- ❒ Asthma
- ❒ Blood Transfusion
- ❒ Cancer
- ❒ Chemotherapy
- ❒ Colitis
- ❒ Congenital Heart Defect
- ❒ Diabetes
- ❒ Difficulty Breathing
- ❒ Drug Abuse
- ❒ Emphysema
- ❒ Epilepsy
- ❒ Facial Surgery
- ❒ Fainting Spells
- ❒ Fever Blisters
- ❒ Frequent Headaches
- ❒ Glaucoma
- ❒ HIV+ AIDS
- ❒ Heart Attack
- ❒ Heart Murmur
- ❒ Heart Surgery
- ❒ Hemophilia
- ❒ Hepatitis A
- ❒ Hepatitis B
- ❒ Hepatitis C
- ❒ High Blood Pressure
- ❒ Joint Replacement
- ❒ Kidney Problems
- ❒ Liver Disease
- ❒ Low Blood Pressure
- ❒ Mitral Valve Prolapse
- ❒ Pace Maker
- ❒ Psychiatric Problems
- ❒ Radiation Therapy
- ❒ Rheumatic Fever
- ❒ Seizures
- ❒ Sexually Transmitted Disease
- ❒ Shingles
- ❒ Sickle Cell Disease
- ❒ Sinus Problems
- ❒ Stroke
- ❒ Thyroid Problems
- ❒ Tuberculosis
- ❒ Ulcers

Allergies

- ❒ Aspirin
- ❒ Codeine
- ❒ Dental Anesthetics
- ❒ Erythromycin
- ❒ Latex
- ❒ Metals
- ❒ Penicillin
- ❒ Sulfa
- ❒ Tetracycline

Other_____
_____

Y	N	
❒	❒	Do you smoke or use tobacco?

If Female

Y	N	
❒	❒	Are you taking Birth Control Pills?
❒	❒	Are you pregnant? If yes, # of weeks_____
❒	❒	Are you nursing?

Please list any medications you are currently taking: _____
_____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

_____ _____
PATIENT'S SIGNATURE DATE

If patient is a child or requires a guardian:

_____ _____
PARENT/GUARDIAN SIGNATURE DATE