Eagle View Community Health System
"with an eye on your health"

Oquawka Site
PO Box 198
Oquawka, IL 61469
309-867-2770
877-350-2385 (toll-free)
309-867-3205 (fax)

Stronghurst Site
PO Box 240
Stronghurst, IL 61480
309-924-2424
866-346-1337 (toll-free)
309-924-1389 (fax)

Date:_____ Date of Birth:_____ Preferred Name: _____

Patient's Name:_____
Last First Middle

Mailing Address_____

City/State_____ Zip_____

Telephone # _____ Email:_____ Social Security Number: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Gender: ❑ Male ❑ Female ❑ Undifferentiated
Please list preferred pronouns: _____

Gender Identity: ❑ Male ❑ Female ❑ Male to Female ❑ Female to Male ❑ Other (Please Specify): _____

Sexual Orientation: ❑ Bisexual ❑ Lesbian, Gay or Homosexual ❑ Choose not to disclose ❑ don't know ❑ Straight or Heterosexual ❑ Other (Please describe) _____

Race/Ethnicity: ☐ White (not Hispanic or Latino) ☐ Black/African American (not Hispanic or Latino) ☐ Hispanic or Latino (all races) ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander

Employer _____ Business Phone # _____ Ext _____

Spouse's Name _____ Date of Birth _____

Emergency Contact Name _____ Phone # _____

DENTAL INSURANCE
Ins. Co. Name Policy Holder Policy Holder DOB & Social Security # Group Policy
Employer & Phone #

_____

Physician's Name _____ Phone # _____

Last Visit to Physician_____/_____/_____

Previous Dentist's Name_____ Date last seen _____

(Women ONLY) Are you pregnant? Yes ☐ No ☐ Due date: _____ Nursing? Yes ☐ No ☐

Taking birth control pills? Yes ☐ No ☐

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

If Yes, describe: _____

Pharmacy Name _____ Phone _____

Have you ever been diagnosed with any health conditions that require a pre-medication antibiotic 1 hour before dental treatment? (i.e. joint replacement) Yes ☐ No ☐

Have you ever been treated with IV or oral bisphosphonates (drugs commonly used to treat osteoporosis or cancer i.e. Fosamax, Boniva, Aredia, Zometa)? Yes ☐ No ☐

Allergy to Drugs: Sulfa, Latex, Penicillin, Aspirin, Codeine, or Other Drugs: Yes ☐ No ☐
Please specify:

_____

Please list all medications, vitamins or herbal supplements you are currently taking:

_____

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

Alcohol dependency	Yes ☐ No ☐	Herpes	Yes ☐ No ☐	Physical/Mental	Yes ☐ No ☐
Allergies/hay fever	Yes ☐ No ☐	Fainting or dizziness	Yes ☐ No ☐	Radiation Treatment	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Respiratory Disease	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Headaches	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Artificial Heart Valves	Yes ☐ No ☐	Heart disease	Yes ☐ No ☐	Shortness of breath	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Hepatitis Type_____	Yes ☐ No ☐	Sinus trouble	Yes ☐ No ☐
Autism	Yes ☐ No ☐	HIV/AIDS	Yes ☐ No ☐	Stents	Yes ☐ No ☐
Bleeding Abnormally	Yes ☐ No ☐	Jaundice	Yes ☐ No ☐	Swollen Neck Glands	Yes ☐ No ☐
Blood disease	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Jaw Pain	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐
Chemotherapy	Yes ☐ No ☐	Joint Replacement		Tuberculosis	Yes ☐ No ☐
Circulatory problems	Yes ☐ No ☐	(Knee, Hip, etc.)	Yes ☐ No ☐	Tumor or growth on	
Congenital Heart Lesions	Yes ☐ No ☐	Kidney Disease	Yes ☐ No ☐	head or neck	Yes ☐ No ☐
Cortisone Treatments	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐	Ulcer	Yes ☐ No ☐
Cough, persistent	Yes ☐ No ☐	Low Blood Pressure	Yes ☐ No ☐	Depression	Yes ☐ No ☐
Bruise Easily	Yes ☐ No ☐	Hearing Loss	Yes ☐ No ☐	Recreational drugs (i.e. Meth,	
Diabetes	Yes ☐ No ☐	Pacemaker	Yes ☐ No ☐	Cocaine, Ecstasy)	Yes ☐ No ☐
Emphysema	Yes ☐ No ☐	Psychiatric Care	Yes ☐ No ☐	Smoking	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐			*Desire to quit*	Yes ☐ No ☐

Please explain any "Yes" answers: _____

Any other conditions/diseases or disorders known at this time: _____

1. The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. To the best of my knowledge, the above information is complete and accurate. I understand that even though I may have some type of insurance coverage, I am responsible for payment for services rendered. I authorize release of any information to my insurance company relating to my dental claims.
3. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with *(name of patient)* _____.

Signature of Guardian/Patient _____ Date _____