Today's Date: _____

Patient Name_____ Male ( ) Female ( )
Last First Initial

Preferred Name:_____ Birth Date_____ Age: _____ SS#: _____

Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( )

Address _____ City/State/ Zip _____

Home #:_____ Cell #: _____ Work #: _____

Preferred Contact Number: Home/ Cell / Work Employer Company Name: _____
Email_____

Whom may we thank for referring you? _____

Other family members seen by us:_____

REASON FOR YOUR VISIT TODAY_____
Previous/Present Dentist: _____ Last Visit Date: _____

(Please circle)
Do you have Dental Insurance? Yes No Are you the Insured? Yes No

Insured's Name: _____ Insured's Birth date: _____

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Insured's SS # or ID#: _____ Insured's Employer:_____

Group #:_____

Do you have secondary Dental Insurance: Yes No

Insured's Name: _____ Insured's Birth date: _____

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Insured's SS # or ID#: _____ Insured's Employer: ____ _____

Group #:_____

We gladly process your insurance claims on your behalf. Please note that your insurance policy is a contract between you and your insurance carrier. We are an out of network PPO provider.

In the event of an emergency, Please provide a contact: Name _____ Phone #: _____

Relation:_____

DENTAL HISTORY

Check (√) if you have had a problem with any of the following:

□ Bad Breath Dry Mouth	Grinding teeth	□ Sensitivity to hot
□ Bleeding gums	□ Loose teeth or broken fillings	□ Sensitivity to sweets
□ Clicking or popping jaw	□ Periodontal treatment	□ Sensitivity when biting
□ Food collection between teeth	□ Sensitivity to cold	□ Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit_____

Have you had any serious illnesses or operations? _____ If yes, describe_____
_____

(Women) Are you pregnant? □Yes □ No Nursing? □Yes □ No Taking birth control pills? □Yes □ No

Check (√) if you have or have had any of the following:

□ AIDS	□ Congenital Heart Lesions	□ Hepatitis	□ Rheumatic Fever
□ Anemia	□ Cortisone Treatments	□ Hernia Repairs	□ Scarlet Fever
□ Arthritis, Rheumatism	□ Cough, Persistent	□ High Blood Pressure	□ Shortness of Breath
□ Artificial Heart Valves	□ Cough up blood	□ HIV Positive	□ Skin Rash
□ Artificial Joints	□ Diabetes	□ Jaw Pain	□ Stroke
□ Asthma	□ Epilepsy	□ Kidney Disease	□ Swelling of Feet / Ankles
□ Back Problems	□ Fainting	□ Liver Disease	□ Thyroid Problems
□ Bleeding Abnormally	□ Glaucoma	□ Mitral Valve Prolapse	□ Tobacco Habit
□ Blood Disease	□ Headaches	□ Nervous Problem	□ Tonsillitis
□ Cancer	□ Heart Murmur	□ Pacemaker	□ Tuberculosis
□ Chemical Dependency	□ Heart Problem	□ Psychiatric Care	□ Ulcer
□ Chemotherapy	Describe_____	□ Radiation Treatment	□ Venereal Disease
□ Circulatory Problems	□ Hemophilia	□ Respiratory Disease	□ Other:_____

Have you ever taken any of these medications? And, WHEN? _____

Diet Medications:	□ Dexfenfluramine	Fen-phen	□ Pondimin	□Redux	
Blood Thinners:	□ Coumadin	Warfarin	BISPHOSPHONATE:	BONIVA	FOSMAX
Other:	□ Levoxyl	Synthroid		RECLAST	ACTONEL

Do you require antibiotics before dental treatment? Yes No

MEDICATIONS

List medications you are currently taking_____
_____
_____

Pharmacy Name _____ Phone_____

ALLERGIES

□ Aspirin	□ Penicillin
□ Barbiturates (Sleeping Pills)	□ Sulfa
□ Codeine	□ Latex
□ Local Anesthetic	□ Other ____

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_X_____ X_____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Patient Name: _____ Today's Date: _____

Are you wearing a removable denture or partial denture? YES NO
If so, how long have you been wearing it or them? _____

Please circle the letter of the response that is closest to yours:

My mouth is:
A. Very comfortable
B. Moderately comfortable
C. Uncomfortable

I:
A. Follow the dentist's recommendations
B. Sometimes follow recommendations
C. Rarely go and don't care about dentistry

I have:
A. Set goals for my dental health
B. Never set goals but would like to
C. Never set goals, nor will I

I put dentistry:
A. High on my priority list
B. Low on my priority list
C. On my list but hard to find

I:
A. Will do anything to keep my teeth
B. Want to keep my teeth but have a limited budget
C. Believe losing my teeth is part of aging

I am
A. Very satisfied with the appearance of my mouth
B. Somewhat satisfied with the appearance of my mouth
C. Dissatisfied with the appearance of my mouth

My present state of dental health is:

A. Excellent
B. Good
C. Poor

Thank you for filling out these forms completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

We want our office to have a friendly and personable atmosphere. We will work together as a team to offer our patients the latest techniques in dentistry. Our office constantly takes continuing education courses which enable us to perform dentistry which exceeds the standard of care today.

We have committed ourselves to the total well being of our patients. We will be compassionate and understanding of their dental concerns. We value each and every person in our practice. We strive for constant improvement and excellence. We strive to develop confidence and a feeling of accomplishment with our patients..

World Class Smiles Chicago