



*Thank you for selecting our dental office. We will strive to provide you with the best possible care. To help us meet all your dental goals, please complete these forms.*

**Patient Information** (CONFIDENTIAL)

Date \_\_\_\_\_

Name \_\_\_\_\_ Birthday \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

What is the best number to reach you at? \_\_\_\_\_ What Time \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

Spouse Name \_\_\_\_\_ Occupation \_\_\_\_\_ Any Children? \_\_\_\_\_

If Full time Student, Name of School/ College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

**Responsible Party**

Name of Person Responsible for this Account \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Is this Person Currently a Patient in our Office?  Yes  No

**Dental Insurance Information**

Will some of your dental work be covered by insurance?  Yes  No

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Ins Co Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE ?  Yes  No IF YES, COMPLETE THE FOLLOWING...**

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Ins Co Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

# Health History (CONFIDENTIAL)

Have there been any problems in your general health within the past 5 years? (Serious illness, hospitalization, surgery, etc.)

Yes  No If yes, please explain \_\_\_\_\_

Have you had any form of Cancer?  Yes  No If so what type? \_\_\_\_\_

Date of last medical check up \_\_\_\_\_ Attending Physician \_\_\_\_\_

Date of last blood test \_\_\_\_\_ Attending Physician \_\_\_\_\_

Are you currently under a physician care now?  Yes  No If yes, please explain \_\_\_\_\_

Please list any medications you are currently taking (vitamins, drugs, pain pills, herbs, etc.) \_\_\_\_\_

Are you required to take any medication before having dental work done?  Yes  No If yes, what? \_\_\_\_\_

Have you had a positive test for the aids virus (HIV+)?  Yes  No What date? \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone # \_\_\_\_\_

## DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

- | Yes                      | No                       |  | Yes                      | No                       |                                     |
|--------------------------|--------------------------|--|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever, Rheumatic heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur, Mitral valve prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating disorder                          | <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble, Heart attack         |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in chest, Shortness of breathe      | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure, Stroke         |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood disorder, Anemia                   | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Positive test for venereal disease       | <input type="checkbox"/> | <input type="checkbox"/> | Asthma or Hay Fever                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold sores, Herpes incident              | <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney trouble                           | <input type="checkbox"/> | <input type="checkbox"/> | Bruise easily, Abnormal bleeding    |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation treatment                      | <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells, Seizures           |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A, B or C                      | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice, Liver disease             |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                                | <input type="checkbox"/> | <input type="checkbox"/> | Persistent cough                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Sores that do not heal in 1 week         | <input type="checkbox"/> | <input type="checkbox"/> | Artificial joint replacement        |
| <input type="checkbox"/> | <input type="checkbox"/> | Organ transplant                         | <input type="checkbox"/> | <input type="checkbox"/> | Swollen ankles                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Back trouble or surgery                  | <input type="checkbox"/> | <input type="checkbox"/> | Whiplash injury                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis                             | <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke _____ pk per _____     |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism                               | <input type="checkbox"/> | <input type="checkbox"/> | Drug addiction                      |

## FOR WOMEN ONLY

Are you pregnant? Due Date \_\_\_\_\_   Taking birth control pills?

Do you have any disease, condition or problem not listed above that we should know about? \_\_\_\_\_

## ARE YOU SENSITIVE OR ALLERGIC TO ANY OF THE FOLLOWING?

- | Yes                      | No                       |            | Yes                      | No                       |              | Yes                      | No                       |         |
|--------------------------|--------------------------|------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|---------|
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin | <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin | <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin    | <input type="checkbox"/> | <input type="checkbox"/> | Pain Pills   | <input type="checkbox"/> | <input type="checkbox"/> | Metals  |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex      | <input type="checkbox"/> | <input type="checkbox"/> | Vinyl        | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa   |
| <input type="checkbox"/> | <input type="checkbox"/> | Tylenol    | <input type="checkbox"/> | <input type="checkbox"/> | Ibuprofen    | <input type="checkbox"/> | <input type="checkbox"/> | Acrylic |

Anything not listed above \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# Dental History (CONFIDENTIAL)

Correct answers to the following questions will allow our office to treat you on a more individual basis, providing the care appropriate for your needs. Your answers are for our records only and will be considered confidential.

Do you visit the dentist regularly?  Yes  No

Date of last dental: Visit \_\_\_\_\_ Exam \_\_\_\_\_ X-rays of all of your teeth \_\_\_\_\_

How often do you brush? \_\_\_\_\_ Do you avoid brushing any part of your mouth? \_\_\_\_\_

Do you brush your teeth  vigorously  lightly My brush is:  Soft  Medium  Hard

Does dental treatment make you nervous?  No  Slightly  Moderately  Extremely

What can we do to make you more comfortable? \_\_\_\_\_

Have you ever been treated for periodontal disease? (Gum disease, pyorrhea, trench mouth)  Yes  No

Do you have any of the following:

MOUTH	Yes	No	TEETH	Yes	No
Bleeding, sore gums	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/bad breathe	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to hot	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue/lips	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to cold	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blister, lips/mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to sweets	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/lumps in mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to biting	<input type="checkbox"/>	<input type="checkbox"/>
Biting cheeks/lips	<input type="checkbox"/>	<input type="checkbox"/>	Food Impaction	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any missing teeth?  Yes  No If so, how long have they been missing? \_\_\_\_\_

Why didn't you have them replaced? \_\_\_\_\_ Was it ever suggested? \_\_\_\_\_

Have you ever had braces?  Yes  No If yes, what calendar years? \_\_\_\_\_

Do you chew on both sides of your mouth?  Yes  No If no, please explain \_\_\_\_\_

Do you have a tired feeling in your face while chewing or at the end of the day after considerable talking?  Yes  No

Have you ever had a reaction to a dental anesthetic or any problems with dental work?  Yes  No If yes, please explain \_\_\_\_\_

Are you aware of your jaw clicking or popping while you are eating or yawning?  Yes  No How often? \_\_\_\_\_

Do you have headaches, chronic neck or shoulder pain?  Yes  No If yes, where? \_\_\_\_\_

Do you clench or grind your teeth?  Yes  No Has anyone made you aware that you do this? \_\_\_\_\_

Do you know that decay and gum disease can occur without your being aware of it?  Yes  No

Are you having any discomfort at this time?  Yes  No If yes, please explain \_\_\_\_\_

Is there anything else you would like us to know? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

## SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Janet Mc Mullen**

Telephone: **(630) 469-3558**

Fax: **(630) 469-9912**

Address: **45 South Park Blvd. Suite 190 Glen Ellyn, IL 60137**

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

## SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_