



45 South Park Blvd., Suite 190
Glen Ellyn, Illinois 60137
(630) 469-3558

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 _____
Birth date _____ 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 1week | <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** _____

Dr. John C. Workman

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: _____

REVOCACTION 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: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**