The Delicate Art of Dentistry

5319 N. Sheridan Rd.

Chicago, IL 60640

Date_____

Patient Information:

Social Security #_____-____-_____

Name _____**Birth date** _____ **Phone** _____

Address_____ **City**_____ **State**_____ **Zip**_____

E-mail_____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Employer _____**Work Phone** _____

Business Address _____**City** _____**State** _____ **Zip** _____

Whom may we thank for referring you? _____

Responsible Party: (If someone other than yourself will be paying for your services)

Name: _____**Relationship to Patient** _____

Billing Address _____**City** _____**State** _____**Zip**_____

Phone _____**Work Phone** _____**Social Security** _____-____-_____

Is this person currently a patient in our office? _____

In Event of Emergency:

Whom Should We Contact? _____ **Relationship to Patient**_____

Home Phone _____**Work Phone** _____**Cell Phone** _____

Who is your Medical Doctor? _____

Insurance Information:

Name of Insured _____**Relationship to Patient** _____

Date of Birth of Insured _____**Social Security # of Insured** _____-_____-_____

Insured's Employer_____ **Phone #** _____

Insurance Company Name_____ **Phone #** _____

Group Number: _____ **Patient ID Number:** _____

Patient Medical History: (Please Circle)

-Are you under medical treatment now?	YES NO	Are you allergic or have you had a reaction to any of the following?	
-Have you ever been hospitalized for a surgical operation or serious illness?	YES NO	Local Anesthetics	YES NO
-Do you use any kind of tobacco?	YES NO	Penicillin	YES NO
-Do you suffer from addiction to alcohol, cocaine, or other drugs of any kind?	YES NO	Sulfa Drugs	YES NO
		Erythromycin	YES NO
		Sedatives	YES NO
		Codeine	YES NO
		Aspirin	YES NO
----------Women Only----------		Latex	YES NO
Are you pregnant or think you might be?	YES NO	Other (Please specify in the space below):	
Are you nursing?	YES NO		
Are you taking birth control pills?	YES NO		

Do you have or have you had any of the following?

High Blood Pressure	YES	NO
Heart Attack	YES	NO
Rheumatic Fever	YES	NO
Swollen Ankles	YES	NO
Fainting/Seizures	YES	NO
Asthma	YES	NO
Low Blood Pressure	YES	NO
Epilepsy/Convulsions	YES	NO
Leukemia	YES	NO
Diabetes	YES	NO
Kidney Diseases	YES	NO
AIDs or HIV Infection	YES	NO
Thyroid Problem	YES	NO
Heart Disease	YES	NO
Stroke	YES	NO
Hay Fever/Allergies	YES	NO
Tuberculosis	YES	NO
Radiation Therapy	YES	NO
Glaucoma	YES	NO
Recent Weight Loss	YES	NO

Cardiac Pacemaker	YES	NO
Heart Murmur	YES	NO
Angina	YES	NO
Frequently Tired	YES	NO
Anemia	YES	NO
Emphysema	YES	NO
Cancer	YES	NO
Arthritis	YES	NO
Joint Replacement	YES	NO
Hepatitis/Jaundice	YES	NO
Sexually Trans. Disease	YES	NO
Stomach Troubles	YES	NO
Chest Pains	YES	NO
Easily Winded	YES	NO
Liver Disease	YES	NO
Heart Trouble	YES	NO
Respiratory Problems	YES	NO

Medications Taken at This Time:

Name of Medication:

_____

_____

_____

_____

_____

_____

_____

_____

Reason for Medication:

_____

_____

_____

_____

_____

_____

_____

_____

Patient Dental History:

Please circle any of the following problems:			Have you ever had any difficult extraction in the past?	Yes	No
A) Discomfort, clicking or popping jaw.	Yes	No	Have you had any orthodontic work?	Yes	No
B) Red, swollen or bleeding gums.	Yes	No			
C) Sensitive tooth, teeth or gums.	Yes	No	Have you ever had any prolonged bleeding following extraction?	Yes	No
D) Blisters/ sores in or around mouth.	Yes	No			
E) Lost / broken filling(s)	Yes	No	Have you ever had instruction on the correct method brushing your teeth?	Yes	No
F) Teeth grinding	Yes	No			
G) Ringing in ears	Yes	No	Have you ever had instruction on the care of your gums?	Yes	No
H) Broken/ Chipped teeth	Yes	No			
I) Stained teeth	Yes	No			
J) Locking jaw	Yes	No			

Any specific questions or concerns you want us to address:

_____
_____
_____
_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge.
The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care third party and/ or health practitioners. I authorize and request my Insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature_____ Date_____

---------- Do Not Write Below This Line ----------
Doctor's Comments:

Doctor's Signature: _____ Date: _____