



Welcome to our practice!

Thank you for selecting us to be your dental team. Please fill out this form completely and to the best of your knowledge. Print clearly. If you have any concerns or questions about this form ask for assistance from our friendly staff.

Name: _____ Birth Date: _____ Gender: M F
(First) (Last) (Middle)

Home Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Soc. Sec. #: _____

Please Check: Single _____ Married _____ Separated _____ Widowed _____ Divorced _____

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ ZIP: _____

Spouse/Guardian Name: _____ Work or Cell Phone: _____

Person to contact in case of emergency: _____ Phone: _____

We are always grateful for a referral. Whom may we thank for referring you? _____

Responsible Party for this account (if different from above)

Name: _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____ Soc. Sec #: _____

Primary Insurance

Group #: _____ Subscriber: _____ ID#: _____

Insurance Company: _____ Subscriber D.O.B.: _____

Secondary Insurance

Group #: _____ Subscriber: _____ ID#: _____

Insurance Company: _____ Subscriber D.O.B.: _____

Office Policies

Payment in full is expected at the time services are rendered. For patients with insurance you must pay your entire co-pay at the treatment visit. By signing below, you authorize direct payment of dental benefits otherwise payable to you, to Dental Care of Vernon Hills. Any insurance claims that are denied or remain unpaid at 30 days are considered past due. If you wish to make special payment arrangements you must speak to the office manager. We accept Visa/Mastercard/AMEX/Discover, Cash, Check, Debit, Care Credit, and Chase Advance. There is a fee of \$25 for all returned checks. Delinquent accounts may be sent to collection agency and collection fees may apply.

By missing an appointment you block other patients from getting treatment. You will be charged a \$50 for each appointment that you do not call to reschedule at least 24 hours in advance of the appointment time. Any patient missing more than 2 appointments in a 12 month period may not be allowed to reschedule.

Sign: _____

Date: _____

Dental History

Previous Dentist: _____ Date of Last Exam: ___/___/___

- | | Yes | No |
|--|--------------------------|--------------------------|
| Are you having any dental problems that you are aware of? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a history of gum disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any clicking, popping or discomfort in jaw joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you feel nervous about dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a bad experience in a dental office | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had any complications after dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you happy with your smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| Would you like whiter teeth? | <input type="checkbox"/> | <input type="checkbox"/> |

Medical History

Current Physician: _____ Date of Last Exam: ___/___/___

- | | Yes | No |
|---|--------------------------|--------------------------|
| Are you currently under a physician’s care for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been hospitalized in the last two years for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you taken any prescription medications in the last two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently taking any vitamins, herbal supplements, or “cures” | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you on a special diet? (explain) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you smoke or chew tobacco? (years) _____ (packs per day) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use recreational drugs (marijuana, cocaine, methamphetamine)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you consume alcohol? Daily Weekly Within last 24 hours | | |
| Do you have any drug/substance allergies? (list) _____ | | |
| Please list current medications: | | |

Preferred Pharmacy: _____ Phone: _____

Women Only: Oral contraceptive Y N Nursing Y N Pregnant Y N Due Date: _____

Do you have or have you had any of the health problems listed below?

	Yes	No		Yes	No		Yes	No
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Change	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hep A, B, or C	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>

I have answered every question to the best of my knowledge. I understand improper information can be dangerous to my safety during dental treatment. I consent to complete oral examination and necessary x-rays.

Sign: _____ Date: _____