WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.

About You

Today's Date: _____

Email Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐Male ☐Female

Birthdate: ____/____/____ Age: ____ SS#: _____-____-_____

Home Address: _____
Apt/Condo #

_____
City State Zip Code

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (_____)_____ Cell #:(_____)_____

Wk #: (____)_____ Ext:_____ DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Last Visit Date: _____

Spouse Information

His/Her Name: _____

Employer: _____

Wk #: (____)_____ Ext:_____ SS#: _____-___-_____

Birthdate: ____/____/_____ DL#:_____ _____

Person Responsible for Account: _____

Hm #: (_____)_____ Cell #: _____)_____

Billing Address: _____

Relationship: _____ SS#: _____-____-_____

Employer: _____ DL#: _____

Insurance

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation:_____

Insured's Birthdate: ____/____/____ ID#: _____-____-_____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐Yes ☐No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation:_____

Insured's Birthdate: ____/____/____ ID#: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or Relative not living with you (for emergency).

His/Her Name: _____ Relation: _____

Hm#: (_____)_____ Wk#:(_____)_____

Address: _____

_____

Medical History

Do you have a personal physician? ☐Yes ☐No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

Are you currently under the care of a physician? ☐Yes ☐No

Please Explain: _____

_____

Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription/over the counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women:

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Herpes/Fever Blisters
Y N Alcohol/Drug Abuse	Y N High Blood Pressure
Y N Anemia	Y N HIV+/AIDS
Y N Arthritis	Y N Hospitalized for any reason
Y N Artificial Bones/joins/valves	Y N Kidney Problems
Y N Asthma	Y N Liver Disease
Y N Blood Transfusion	Y N Low Blood Pressure
Y N Cancer/Chemotherapy	Y N Lupus
Y N Colitis	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Osteoporosis/Paget's Disease
Y N Diabetes	Y N Pacemaker
Y N Difficulty Breathing	Y N Psychiatric Treatment
Y N Emphysema	Y N Radiation Treatment
Y N Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Fainting Spells	Y N Seizures
Y N Frequent Headaches	Y N Shingles
Y N Glaucoma	Y N Sickle Cell Disease/Traits
Y N Hay Fever	Y N Sinus Problems
Y N Heart Attack	Y N Stroke
Y N Heart Murmur	Y N Thyroid Problems
Y N Heart Surgery	Y N Tuberculosis (TB)
Y N Hemophilia	Y N Ulcers
Y N Hepatitis	Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other
Y N Dental Anesthetics	Y N Penicillin	

Please List any other drugs/materials that you are allergic to: _____

_____

_____

Dental History

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you have fears about going to the dentist? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain/ discomfort in your jaw joint? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐Yes ☐ No

How many times a week do you floss? ____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it?

Are your teeth sensitive to heat, cold, or anything else?

Have you lost any teeth? ☐Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Payment is due in full at the time of treatment
Unless prior arrangements have been approved

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. All treatment plans for future dental work are estimated per your insurance coverage I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Consent to Dental Photography: I authorize New Lenox Dental Group to take photographs, and/or videos of my face, jaws, and teeth, before, during and after treatment. I consent to allow the photographs to be used for:

- Dental Records and Dental Research,
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites and printed materials, patient education.

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature (Patient or Guardian) _____ Date: _____

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____