

OAK PARK PATIENT INFORMATION & REGISTRATION

PATIENT'S LAST NAME _____ First _____ MI _____ Preferred Name _____ Today's Date _____
 BIRTHDATE _____ AGE _____ GENDER (M/F) _____ MARITAL STATUS _____ SOC. SEC. # _____
 RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____
 MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____
 PHONE #'S Home _____ Work _____ Ext _____ FAX _____ Pager/Cell _____
 E-MAIL _____ (If you would like to communicate with us via e-mail) EMPLOYER _____ Occupation _____
 Whom may we Thank for Referring You to our office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

LAST NAME _____ First _____ MI _____ Preferred Name _____ Today's Date _____
 BIRTHDATE _____ AGE _____ GENDER (M/F) _____ MARITAL STATUS _____ SOC. SEC. # _____
 RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____
 MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____
 PHONE #'S Home _____ Work _____ Ext _____ FAX _____ Pager/Cell _____
 E-MAIL _____ (If you would like to communicate with us via e-mail) EMPLOYER _____ Occupation _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
 EMPLOYER _____ # OF YEARS EMPLOYED _____
 OCCUPATION _____ Soc. Sec. # _____
 WORK PHONE _____ BIRTHDATE _____

EMERGENCY INFORMATION (RELATIVE NOT LIVING WITH YOU)

NAME _____
 ADDRESS _____
 CITY, _____ STATE _____ PHONE _____

DENTAL INSURANCE INFORMATION

Insured's Name _____
 Insurance Co. _____ Phone _____
 Insurance Co Address _____
 Insured's Employer _____
 Insured's Soc. Sec. # _____ Group # _____

If you have double dental insurance coverage, please complete this section for the second coverage.

Insured's Name _____
 Insurance Co. _____ Phone _____
 Insurance Co Address _____
 Insured's Employer _____
 Insured's Soc. Sec. # _____ Group # _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL/MEDICAL HISTORY

How LONG SINCE you last saw Dentist?
 Last COMPLETE Dental EXAM Date:
 Last FULL MOUTH X-RAYS Date:
 Are you having DENTAL PROBLEMS NOW? Describe:
 Is your present dental health POOR?
 Do you wear DENTURES? (Partials of full)
 Would you like to know more about PERMANENT REPLACEMENTS?
 Are you APPREHENSIVE about dental treatment?
 Have you had any PERIODONTAL (GUM) TREATMENT?
 Do your gums BLEED or feel TENDER or IRRITATED?
 Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)
 Are you UNHAPPY with the APPEARANCE of your teeth?
 Do you have HEADACHES, EARACHES, OR NECK PAINS?
 Have you worn BRACES ON YOUR TEETH (orthodontics)?
 Do you have DISCOLORED teeth that bother you?
 Would you like your smile to LOOK BETTER or DIFFERENT?
 Do you REGULARLY use DENTAL FLOSS?
 Name of PREVIOUS DENTIST:
 City: _____ State: _____ Phone: _____
 Do you have any CURRENT HEALTH PROBLEMS?
 Explain:
 Are you PREGNANT?
 Do you Smoke or Use Tobacco Products

YES NO

Are you allergic to or have you reacted adversely to any of the following? (Please circle)

Aspirin Local Anesthetic Erythromycin Latex Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications or substances? Please list:

Circle any of the following which you have had or presently have:

AIDS/HIV Pos.	Epilepsy	Psychiatric care
Allergy (latex, wool, metal, chemicals)	Fainting	Rapid weight gain/loss
Anaphylaxis	Food allergies	Radiation treatment
Anemia	Glaucoma	Respiratory disease
Arthritis (Rheumatism)	Headaches	Rheumatoid/scarlet fever
Artificial joints or valves	Heart murmur	Shingles
Asthma	Heart Problems (Describe)	Shortness of breath
Back problems	Hemophilia	Skin rash
Blood disease	Herpes	Spina Bifida
Cancer	Hepatitis	Stroke
Chemical dependency	High blood pressure	Surgical implant
Chemotherapy	Jaw pain	Swelling of feet or ankles
Circulatory problems	Kidney disease/malfunction	Thyroid disease/malfunction
Cortisone treatments	Liver disease	Tonsillitis
Cough (Persistent)	Mitral valve prolapse	Tuberculosis
Diabetes	Nervous problems	Ulcer/Colitis
	Pacemaker/heart surgery	Venereal Disease

How do you feel about your teeth?
 Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment?
 FEAR of pain # LACK of concern #
 COST of treatment # MISSING work time #

Physician: _____ Phone: _____

Have you ever taken any of these medications for osteoporosis or cancer? (Circle)
 Fosamax Actonel Boniva Aredia, Zometa

What MEDICATIONS OR SUPPLEMENTS are you now taking?

List any other medical or dental information that you feel I should know about now:

Consent

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.

Patient Signature (Parent of Child) _____ Date _____ Dentist Signature _____