CHICAGO
DENTAL SMILES

PATIENT INFORMATION

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First Name:

Last Name:

Name you prefer to be called by:

Gender:
☐ Male ☐ Female

Marital Status:
☐ Married ☐ Single ☐ Divorced ☐ Widowed

Patient is:
☐ Policy Holder ☐ Resp. Party

Address:

City/State/Zip:

Home Phone:

Mobile Phone:

Work Phone:

Birth Date:

Social Security Number:

Drivers License Number:

Email Address:

Receive Email and/or Text Updates:
☐ Email Updates ☐ Text Updates

CHILD INFORMATION (IF THE PATIENT IS A CHILD, COMPLETE SECTION)

First Name:

Last Name:

Name child prefers to be called by:

Gender:
☐ Male ☐ Female

Birth Date:

Social Security Number (Child):

Address: (if different than the above)

City/State/Zip:

GETTING TO KNOW YOU

Were you referred here? If so, by who?

Emergency Contact:

Closest relative not living with you:

Relationship with referrer:

Emergency Contact Relationship:

Relationship:

Phone Number:

Phone Number:

RESPONSIBLE PARTY INFORMATION

First Name:

Last Name:

Relationship to Patient:

Address:

City:

State:

Zip Code:

Occupation:

Employer's Name:

Employer's Phone:

INSURANCE INFORMATION

PRIMARY CARRIER INSURANCE INFORMATION

Insurance Company:

Group Number:

Member ID Number:

Insured's Name:

Insured's Date of Birth:

Relationship to Patient:

Insurer's Phone:

SECONDARY CARRIER INSURANCE INFORMATION

Insurance Company:

Group Number:

Member ID Number:

Insured's Name:

Insured's Date of Birth:

Relationship to Patient:

Insurer's Phone:

DENTAL HABITS/HISTORY

GENERAL INFORMATION

What is the reason for your visit today:

Date of last dental visit:

Date of last dental cleaning:

Previous Dentist's Name:

ABOUT YOUR DENTAL HABITS

How often do you have your teeth examined:

How often do you brush your teeth:

How often do you floss:

Do you have any dental problems now? If yes, please describe:

ARE YOUR TEETH SENSITIVE TO (CHECK IF YES):

Hot or Cold:

Sweets:

Biting or Chewing:

DO YOU EXPERIENCE ANY OF THE FOLLOWING (CHECK IF YES):

Mouth odors or bad taste:

Frequent cold sores, blisters or lesions:

Your gums bleed or hurt:

Clinch/grind your teeth:

Food get caught in between teeth:

Use tobacco products:

Snoring/sleeping disorders:

Bite cheeks or lips regularly:

Have tired jaws:

HAVE YOU HAD THESE DENTAL TREATMENTS (CHECK IF YES):

Orthodontic treatment:

Oral surgery:

Periodontal treatment:

A bite plate or mouth guard:

Bite adjusted or teeth ground:

Serious injury to the mouth or head:

HAVE YOU EVER EXPERIENCED (CHECK IF YES):

Clicking/popping of the jaw

Pain (joint, ear, side of face):

Difficulty opening/closing mouth:

Difficulty chewing:

Headaches, neck or shoulder aches:

Satisfied by your teeth's appearance:

Like to keep your teeth for life:

Nervousness about dental treatments:

Had a bad dental experience:

MEDICAL HISTORY

GENERAL INFORMATION

Have you been under the care of a medical doctor during the past two years; if yes, for what:

Physician's Name:

Physician's Address/City/State/Zip:

Physician's Phone:

HAVE YOU HAD ANY OF THE FOLLOWING (CHECK IF YES):

Heart (surgery, disease, attack)	Kidney trouble	Hepatitis A, B or C
Chest pain	Artificial joints (hip, knees, etc)	Venereal disease
Congenital heart disease	Thyroid problems	AIDS/HIV+ postive test result
Heart murmur	Glaucoma	Cold sore/fever blisters
Stroke	Emphysema	Blood transfusion
Mitral valve prolapse	Asthma	Hemophilia
Artifical heart valve	Chronic cough	Sickle cell disease
Heart pacemaker	Tuberculosis	Bruise easily
Rheumatic fever	Hay fever	Liver disease
Arthritis/rheumatism	Allergies or hives	Yellow jaundice
Cortisone meclizine	Latex sensitivity	Neurological disorders
High blood pressure	Sinus trouble	Epilepsy or seizures
Diet (special/restricted)	Chemotherapy	Fainting or dizzy spells
Diabetes	Radiation therapy	Psychiatric/psychological care
Ulcers	Tumors	Nervous/anxious

ADDITIONAL MEDICAL QUESTIONS (CHECK IF YES):

Any medications during last two years:

Medications (inc. ibuprofen, acetaminophen or OTC herbal):

if yes, name and dosage:

Have you even taken any prescription drugs for weight-loss including Fen-Phen, Pondimen, or Redux:

if yes, did you have a medical exam for heart issues::

Have you ever had an allergic or adverse reaction to any medication or substance:

if yes, please list:

Hospitalized during the past five years:

Do you use more than 2 pillows to sleep:

Have you gained more than 10 pounds in the last year:

Do you have or have you had any disease, condition or problem not listed previously:

if yes, please list:

Women - Do you use birth control medications:

Women - Are you pregnant or think you may be pregnant:

if yes, please list months

I under the above information is necessary to provide me with dental care in a safe manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information. I will notify the doctor of any changes in my health or medications.

Patient or Guardian Signature

Date