Old Orchard Periodontics and Implant Dentistry
DAVID BARACK D.D.S.
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Skokie,IL 60077
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Patient Name Email
Address City State Zip
Phone Cell Work
Social Security # Birth date
Pharmacy Name/Location Pharmacy #
Referring Dentist Male Female

DENTAL INSURANCE INFORMATION

Insurance Co Insurance Address
Insurance Phone Number Group Number
ID Number Policy Holder
Relationship to Patient Birth date Social Security #
Employer

ADDITIONAL DENTAL INSURANCE INFORMATION

Insurance Co Insurance Address
Insurance Phone Number Group Number
ID Number Policy Holder
Relationship to Patient Birth date Social Security #
Employer

Assignment Of Benefits

I authorize payment of dental benefits to the named provider for professional services rendered and release of any dental information necessary to process claims

Name Date

What is the reason for your visit today?

Date of Last Dental Visit Last Cleaning
How often do you have dental examinations?
How often do you brush your teeth? How often do you floss?
What other dental aides do you use?
If you have any dental problems now; please describe

MEDICAL HISTORY

1. Are you under medical treatment now?
2. Have you ever been hospitalized for any surgical operation or serious illness?
3. Do you use tobacco?
4. Do you use controlled substances?
5. Do you use alcohol?
6. Have you ever taken bisphosphonates?
7. Do you need to pre medicate before dental appointments?

Women only

Are you pregnant or think you may be pregnant?
Are you nursing?
Are you taking birth control pills?

PLEASE INDICATE WHICH OF THE FOLLOWING APPLY TO YOU, CIRCLE ONLY IF ANSWER IS YES

AIDS/HIV positive	Cortisone medicine	Hemophilia	Renal dialysis
Alzheimer 's disease	Diabetes	Hepatitis A	Rheumatic fever
Anaphylaxis	Drug Addiction	Hepatitis B or C	Rheumatism
Anemia	Easily winded	Herpes	Scarlet fever
Angina	Emphysema	High blood pressure	Shingles
Arthritis/Gout	Epilepsy or seizures	Hives or rash	Sickle cell disease
Artificial Heart Valve	Excessive bleeding	Hypoglycemia	Sinus trouble
Artificial Joint	Excessive thirst	Irregular heartbeat	Spina bifida
Asthma	Fainting/dizzy spells	Kidney problems	Stomach/intestinal disease
Blood disease	Frequent cough	Leukemia	Stroke
Blood transfusion	Frequent diarrhea	Liver disease	Swelling of limbs
Breathing problem	Frequent headaches	Low blood pressure	Thyroid disease
Bruise easily	Genital herpes	Lung disease	Tonsillitis
Cancer	Glaucoma	Mitral valve prolapse	Tuberculosis
Chemotherapy	Hay fever	Pain in jaw joints	Tumors or growths
Chest pains	Heart attack/failure	Parathyroid disease	Ulcers
Cold sores/fever blisters	Heart murmurs	Psychiatric care	Venereal disease
Congenital heart disorder	Heart pace maker	Radiation treatments	Yellow jaundice
Convulsions	Heart trouble/disease	Recent weight loss	

DENTAL HISTORY: PLEASE INDICATE WHICH OF THE FOLLOWING APPLY TO YOU, CHECK ONLY IF ANSWER IS YES

Gums bleed while brushing or flossing	Periodontal treatment
Teeth sensitive to hot/cold liquids/foods	Oral surgery
Teeth sensitive to sweet/sour liquids/foods	Orthodontic work
Feel pain to any teeth	Mouth odor/bad taste
Head neck or jaw injuries	Difficulty chewing
Jaw clicking or popping	A bite plate/mouth guard
Pain in joint/ear/side of face	Mouth breath while awake or asleep
Difficulty opening/closing mouth	If you wear a complete/partial denture do you have trouble with it

PRESCRIBED MEDICATIONS:

OVER THE COUNTER MEDICATIONS, VITAMINS, SUPPLEMENTS: