Stinauer family dentistry

Dr. Bob Stinauer
312 W. Main St.
Havana, IL 62644
(309) 543-2975

Dr. John Stinauer
148 N. 5th Ave.
Canton, IL 61520
(309) 226-4717

Dr. Jesse Stinauer
2000 N. Main St.
Lewistown IL 61542
(309) 547-2200

Personal Information

Today's Date: _____

Patient's name: _____

_____

Preferred Name: _____

☐ *male* ☐ *female* *age:* _____

Status: ☐*minor* ☐*single* ☐*married*

Date of birth _____

Social Security # _____

Driver's License # _____

Home Address: _____

_____

_____

Billing Address: _____

(if different) _____

Please check preferred number to contact:

☐ *Home #* _____

☐ *Work #* _____

☐ *Cell #* _____

Preferred method of appointment confirmation:

☐ *Text* ☐ *Phone call*

Email Address: _____

Employer: _____

Occupation: _____

Spouse's name: _____

Do you have children? ☐ *Yes* ☐ *No*

How many? _____

Do you have dental insurance?

☐ *Yes* ☐ *No*

Do we have a copy of your insurance card? ☐ *Yes* ☐ *No*

Person ultimately responsibly for account: _____

Name: _____

Relation: _____

Referred to us by: _____

Insurance Information

Primary insured's name: _____

_____

Relationship to patient: _____

Primary employer: _____

Primary's date of birth: _____

Primary's social security #: _____

Primary's address: _____

_____

_____

Do you have secondary dental insurance? ☐ *Yes* ☐ *No*

Secondary insured's name: _____

_____

Relationship to patient: _____

Secondary's employer: _____

Secondary's date of birth: _____

Secondary social security #: _____

Secondary's address: _____

_____

_____

Do you have any other supplemental insurance? ☐ *Yes* ☐ *No*

In event of emergency

Emergency contact name: _____

_____

Relationship to patient: _____

_____

Preferred number to contact: _____

_____

Who is your medical doctor: _____

_____

Medical doctor's phone #: _____

_____

Dental Information

Reason for today's visit?

☐ *Exam* ☐ *Emergency*

☐ *Consultation*

Are you in pain? ☐ *Yes* ☐ *No*

How long? _____

Do you require premedication before dental treatment? ☐ *Yes* ☐ *No*

If yes, why? _____

Previous Dentist: _____

Approximate date of last dental visit?

_____

Please indicate any of the following problems:

☐ *Lost/Broken filling*

☐ *Dissatisfied with appearance of teeth*

☐ *Broken/chipped tooth*

☐ *Snoring*

☐ *Sleep apnea*

☐ *Clench/Grind teeth*

☐ *Clicking/Discomfort in jaw*

☐ *Sensitive teeth/gums*

☐ *Stained teeth*

☐ *Bad breath*

☐ *Missing teeth/Difficulty chewing*

☐ *Other*

Is there anything you would like to inform the doctor about past/future dental treatment? _____

_____

_____

Medical Health History

Do you have, or have you had, any of the following?

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NAME: _____

DATE: _____

Heart Problems	yes	no
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood problems		
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion	☐	☐
Allergy problems		
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems		
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint problems		
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement *(e.g. total hip, pins, implants)*	☐	☐
date of joint replacement: _____		
Fainting spells, Seizures, or Epilepsy	☐	☐
Strokes	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Cancer/Tumor	☐	☐
Diabetes	☐	☐
If yes, please circle which type:	Type I/Type II	
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? _____		
Do you chew tobacco?	☐	☐

	yes	no
Do you smoke?	☐	☐
If so, how much? _____		
Hepatitis, jaundice or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
History of head injury?	☐	☐
History of alcohol or drug abuse?	☐	☐
Do you have any disease, condition, or problem not listed previously that you feel we should know about?	☐	☐
If so, please describe: _____		

List of current medications: _____

_____

_____

_____

_____

Have you ever been treated for osteoporosis with oral/IV medications? (bisphosphonates)	☐	☐
If yes, which kind and for how long? _____		
During the past 12 months, have you taken any of the following?		
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g. Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drugs/supplements	☐	☐
Other _____		
Are you allergic, or have you reacted adversely, to any of the following?		
Local anesthetics (novocaine)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, aceteminophen, or Ibuprofen	☐	☐
Codeine, demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex	☐	☐
Other _____		
Women		
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: _____		
Are you nursing?	☐	☐

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family dentistry

We invite you to discuss with us any questions regarding our services. The best dental health services are based on mutual respect between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collections agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:_____ Date:___/___/____

Acknowledgment of Receipt of Notice of Privacy Policies

I, _____, have seen a copy of this office's privacy policies.

Print name _____

Address _____

City _____

List family members who are also patients: _____

_____

_____