



# Dental Health of Wheaton

## Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient # \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_

Date \_\_\_\_\_

Birthdate \_\_\_\_\_

### Patient Information (confidential)

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

If Patient is a Student, Name of School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

### Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship To Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Is this Person Currently a Patient in our Office?  Yes  No

### Insurance Information

Name of Insured \_\_\_\_\_ Relationship To Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

Ins. Co Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How Much is your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

**DO YOU HAVE ANY ADDITIONAL INSURANCE?  YES  NO IF YES, COMPLETE THE FOLLOWING:**

Name of Insured \_\_\_\_\_ Relationship To Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_

Ins. Co Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How Much is your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

over please

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

	Yes	No		Yes	No			
1. Are you under medical treatment now? .....	<input type="checkbox"/>	<input type="checkbox"/>	6. Are you allergic to or have you had any reactions to the following? .....	<input type="checkbox"/>	<input type="checkbox"/>			
2. Have you ever been hospitalized for any surgical operation or serious illness? .....	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics .....	<input type="checkbox"/>	<input type="checkbox"/>			
3. Are you taking any medication(s) including non-prescription medicine? .....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other Antibiotics .....	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, what medication(s) are you taking? _____			Sulfa Drugs .....	<input type="checkbox"/>	<input type="checkbox"/>			
			Barbituates .....	<input type="checkbox"/>	<input type="checkbox"/>			
			Sedatives .....	<input type="checkbox"/>	<input type="checkbox"/>			
4. Do you use tobacco? .....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine .....	<input type="checkbox"/>	<input type="checkbox"/>			
5. Are you wearing contact lenses? .....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>			
			Other .....	<input type="checkbox"/>	<input type="checkbox"/>			
			7. Women Only:					
			a) Are you pregnant or think you may be pregnant? ..	<input type="checkbox"/>	<input type="checkbox"/>			
			b) Are you nursing? .....	<input type="checkbox"/>	<input type="checkbox"/>			
			c) Are you taking birth control pills? .....	<input type="checkbox"/>	<input type="checkbox"/>			
9. Do you have or have you had any of the following?								
Yes	No		Yes	No	Yes	No		
High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack .....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles .....	<input type="checkbox"/>	<input type="checkbox"/>	Angina .....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired .....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions .....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss .....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice .....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection .....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Other .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem .....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>			

# Patient Dental History

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing? .....	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite you lips or cheeks frequently? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had any orthodontic work? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries? .....	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever had any prolonged bleeding following extractions? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Have you ever had instruction on the correct method of brushing your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
a) Clicking? .....	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had instruction on the care of your gums? .....	<input type="checkbox"/>	<input type="checkbox"/>
b) Pain (joint, ear, side of face)? .....	<input type="checkbox"/>	<input type="checkbox"/>			
c) Difficulty in opening or closing? .....	<input type="checkbox"/>	<input type="checkbox"/>			
d) Difficulty in chewing? .....	<input type="checkbox"/>	<input type="checkbox"/>			

# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I realize that failure to keep this account current may result in collection activity and agree to pay necessary costs and attorney fees incurred in attempting to collect on this account.

X \_\_\_\_\_  
Signature of patient or parent if minor Date