Date_____

West Suburban Family Dental

Personal Information

First Name_____ MI_____ Last _____
Address_____ Home Phone_____
City_____ State_____ Zip Code_____ Cell Phone _____
Email Address_____ Work Phone _____
Sex: Male / Female Age_____ Birthdate_____ Patient SS#_____
Marital Status: Single / Married / Widowed / Separated / Divorced
Occupation_____ Employer_____
Responsible Party Name _____ Birthdate_____ SS#_____
Referred by: _____

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IN CASE OF EMERGENCY PLEASE CONTACT (Someone NOT living with you)
Name_____ Relationship to patient_____
Address _____ Phone_____
Who is responsible for this account?_____ Relationship to patient_____

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Insurance Information

PRIMARY INSURANCE
Name of Subscriber_____ Relationship to Subscriber: Self / Spouse / Child / Other
Subscriber's Birthdate_____ Group #_____ ID_____
Employer_____ Ins. Company_____
Address_____ Address_____
City, State, Zip_____ City, State, Zip_____
Phone Number_____ Phone Number_____

SECONDARY INSURANCE
Name of Subscriber_____ Relationship to Subscriber: Self / Spouse / Child / Other
Subscriber's Birthdate_____ Group #_____ ID_____
Employer_____ Ins. Company_____
Address_____ Address_____
City, State, Zip_____ City, State, Zip_____
Phone Number_____ Phone Number_____

ASSIGNMENT AND RELEASE
I, the responsible party, certify that I (or my dependent) have insurance coverage with _____.
I authorize and request my dental insurance company to pay directly to West Suburban Family Dental otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize West Suburban Family Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

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Dental History

Reason for today's visit_____
Former Dentist_____ City, State_____
Date of last dental visit_____ Date of last dental X-rays_____
Please indicate if you have had any of the following:

Are you currently in pain?	YES / NO	Sensitivity to hot and cold?	YES / NO
Burning sensation on tongue?	YES / NO	Do you have sores or growths in your mouth?	YES / NO
Any clicking or popping of the jaw?	YES / NO	Dry mouth?	YES / NO

Date_____

Dental History continued…

Do you gums bleed?	YES / NO	Blisters on your lips or mouth?	YES / NO
Have you had periodontal treatment?	YES / NO	Do you habitually clench your jaw at night/day?	YES / NO
Do you have any loose teeth or broken fillings?	YES / NO	Do you breath excessively through your mouth?	YES / NO
Do you have pain in or around your ears?	YES / NO	Sensitivity to sweets	YES / NO
Sensitivity to air?	YES / NO	Do you chew on one side of your mouth?	YES / NO
Do you smoke cigarettes, pipes, or cigars?	YES / NO	Lip or cheek biting	YES / NO
Do you chew tobacco?	YES / NO	Have you had Orthodontic treatment?	YES / NO
Do you bite your nails?	YES / NO	Gums swollen or sensitivity when biting	YES / NO
Do you grind your teeth?	YES / NO	Do you like your smile	YES / NO
Bad breath?	YES / NO	Have you ever had Novocain anesthetic?	YES / NO
Do you or have you ever experienced pain/discomfort in your jaw joint? (TMJ/TMD)	YES / NO	Any reactions or allergic symptoms to Novocain?	YES / NO
Prolonged bleeding following extractions in the past?	YES / NO	Have you ever had a serious or difficult problems associated with previous dental work?	YES / NO
How often do you brush your teeth? _____		How often do you floss your teeth? _____	

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Medical History

Physician's Name_____ Date of last visit_____

Please indicate if you have had any of the following:

Heart Attack / Stroke	YES / NO	Rheumatic Fever	YES / NO	Difficulty Breathing	YES / NO
Emphysema / Glaucoma	YES / NO	Epilepsy/Seizures/Fainting	YES / NO	Blood Disease	YES / NO
Drug / Alcohol Abuse	YES / NO	Heart Surgery	YES / NO	Circulatory problems	YES / NO
Radiation Treatment	YES / NO	Hepatitis	YES / NO	Sinus Trouble	YES / NO
Artificial Bones / Joints	YES / NO	Heart Murmur	YES / NO	Tuberculosis	YES / NO
Psychiatric Care	YES / NO	Venereal Disease	YES / NO	Ulcers	YES / NO
Cancer / Chemotherapy	YES / NO	HIV Positive / AIDS	YES / NO	Diabetes	YES / NO
Blood Transfusion	YES / NO	Pacemaker	YES / NO	Herpes	YES / NO
High/Low Blood Pressure	YES / NO	Mitral Valve Prolapse	YES / NO	Thyroid Problems	YES / NO
Hemophilia/Abnormal bleeding	YES / NO	Tumor or growth on head or neck	YES / NO	Women:	
				- Are you pregnant?	YES / NO
Severe/Frequent Headaches	YES / NO	Artificial Valves	YES / NO	- Due Date: _____	
Congenital Heart Defect	YES / NO	Asthma	YES / NO	- Are you nursing?	YES / NO
Anemia	YES / NO	Arthritis	YES / NO	- Are you on birth control?	YES / NO

ALLERGIES

Are you allergic to any of the following?

- Aspirin
- Codeine
- Iodine
- Latex
- Local Anesthetic
- Penicillin
- Other _____
_____

MEDICATIONS

Please list any medications you are currently taking:

_____

_____

_____

Pharmacy Name_____

Phone_____

- I understand that I am required to pay in full for services rendered at the time of visit, unless other arrangements have been made prior to my dental appointment.
- I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days. I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.
- **I UNDERSTAND THAT THERE IS A $50.00 FEE FOR ALL BROKEN/FAILED APPOINTMENTS WITH LESS THAN 48 HOURS NOITICE.**
- I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs.
- I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims. I understand that it is my responsibility to inform this office of any changes in my medical or dental status.

Responsible Party Signature_____ Date_____