



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 needs, please fill out this form completely in ink. If you have any questions or need assistance, please feel free to ask - we'll be happy to help.

We will earn the right to your Invitation!

Today's Date: ____/____/____

Name: _____ Mr. Mrs. Ms.
Last First Middle Initial

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age _____

SS# _____ - _____ - _____

Home Address _____

Apt/Condo # _____ City _____

State _____ Zip Code _____

Single Married Divorced Widowed Separated

Home Phone: (____) _____ - _____

Work Phone: (____) _____ - _____

Cellular: (____) _____ - _____

Pager: (____) _____ - _____

e mail Address: _____

Whom may we thank for inviting you to our practice? _____

Other family members seen by us: _____

Employer: _____

Employer's Address: _____

City _____ State _____ Zip Code _____

Length of employment: _____ Occupation: _____

Spouse Information:

His/Her Name: _____

Occupation: _____

Work Phone: (____) _____ - _____

Birthdate: ____/____/____

Person Responsible for Account: Same as above Other:

Name: _____

Billing Address: _____

City _____

Address _____

Zip Code _____

Employer: _____

Employer Phone: (____) _____ - _____

Home Phone: (____) _____ - _____

Relationship to Patient: _____

SS# _____ - _____ - _____

In the event of an emergency, whom should we contact?

His/Her Name: _____

Relationship: _____

Home Phone: (____) _____ - _____

Other #: (____) _____ - _____

Primary Insurance

Dental Coverage? Yes No

Insurance Company Name: _____

Address: _____

Phone: (____) _____ - _____

Group Number (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relation: _____

Policy Owner's Birthdate: ____/____/____

SS# _____ - _____ - _____

Policy Owner's Employer: _____

Secondary Insurance

Dental Coverage? Yes No

Insurance Company Name: _____

Address: _____

Phone: (____) _____ - _____

Group Number (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relation: _____

Policy Owner's Birthdate: ____/____/____

SS# _____ - _____ - _____

Policy Owner's Employer: _____

General & Insurance Info.



Medical &

Do you have or have you experienced the following diseases or medical problems?

	Y	N		Y	N
Artificial Bones/Joints/Implants	<input type="checkbox"/>	<input type="checkbox"/>	Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Heart Defect/Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Valves/Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse (MVP)	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox/Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery/Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Herpes/Canker Sores	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma/Poor Vision	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric/Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia/Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hives/Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems/Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid/Deafness	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Cough/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath/Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis/Tonsils Removed	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
Colitis/Ulcers/Stomach Trouble	<input type="checkbox"/>	<input type="checkbox"/>			

Are you allergic or have you had a bad reaction to any of the following?

Latex/Rubber Products	Y <input type="checkbox"/>	N <input type="checkbox"/>	Aspirin/Ibuprofen	Y <input type="checkbox"/>	N <input type="checkbox"/>
Penicillin or Other Antibiotics	Y <input type="checkbox"/>	N <input type="checkbox"/>	Barbiturates/Sedatives	Y <input type="checkbox"/>	N <input type="checkbox"/>
Codeine	Y <input type="checkbox"/>	N <input type="checkbox"/>	Jewelry/Other Metals	Y <input type="checkbox"/>	N <input type="checkbox"/>
Dental Local Anesthetics	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sulfa Drugs	Y <input type="checkbox"/>	N <input type="checkbox"/>

Please list additional drugs that cause allergic reactions: _____

Are you taking any of the following?:

Blood Pressure Medication	Y <input type="checkbox"/>	N <input type="checkbox"/>	Blood Thinners	Y <input type="checkbox"/>	N <input type="checkbox"/>
Antibiotics	Y <input type="checkbox"/>	N <input type="checkbox"/>	Aspirin/Ibuprofen	Y <input type="checkbox"/>	N <input type="checkbox"/>
Digitalis/Heart Medicine	Y <input type="checkbox"/>	N <input type="checkbox"/>	Antihistamines	Y <input type="checkbox"/>	N <input type="checkbox"/>
Insulin/Diabetes Drugs	Y <input type="checkbox"/>	N <input type="checkbox"/>	Thyroid Medicine	Y <input type="checkbox"/>	N <input type="checkbox"/>
Antidepressants	Y <input type="checkbox"/>	N <input type="checkbox"/>	Acetaminophen	Y <input type="checkbox"/>	N <input type="checkbox"/>
Steroids/Cortisone	Y <input type="checkbox"/>	N <input type="checkbox"/>	Nitroglycerin	Y <input type="checkbox"/>	N <input type="checkbox"/>

Are you taking any prescription/over-the-counter drugs not listed above?
If yes, please list each one and the dosage: _____

Do you have a personal physician? Y N

If yes, please include: Physician's Name: _____
Telephone # (____) _____ - _____

How do you rate your current physical health? Excellent Good Fair Poor

For Women Only:

Are you pregnant or planning pregnancy?	Y <input type="checkbox"/>	N <input type="checkbox"/>
Are you breast feeding?	Y <input type="checkbox"/>	N <input type="checkbox"/>
Are you taking birth control pills?	Y <input type="checkbox"/>	N <input type="checkbox"/>
Do you experience any menstrual problems (i.e. Irregularities, excessive bleeding, etc.?)	Y <input type="checkbox"/>	N <input type="checkbox"/>
Are you or have you previously been prone to yeast infections?	Y <input type="checkbox"/>	N <input type="checkbox"/>
Do you take hormone replacement therapy?	Y <input type="checkbox"/>	N <input type="checkbox"/>
If so, what is the name & dosage of the medication?	_____	



Are you currently under the care of a physician for any illness? Y N
 If yes, Please explain: _____

Do you smoke or use tobacco in any other form? Y N

Do you use alcohol? Y N

Do you use recreational drugs? Y N

Which type(s)? _____

Do you wear contact lenses? Y N

Do you have any disease, condition or problem not listed that you think I should know about?

Have you been hospitalized for any surgical operation or serious illness within the past 5 years? Y N

If yes, please explain: _____

Do you have or have you ever had a history of photosensitive reactions or using photosensitizing drugs? Y N

If yes, please explain: _____

Do you take any herbal/holistic medications? Y N

If yes, please list _____

Are you dieting and/or taking any weight loss medication? Y N

Do you have or did you ever have any eating/nutrition disorder? Y N

Do you have a restrictive diet? Y N

Why have you come to the dentist today?

When was your last dental examination and professional cleaning ____/____/____

Are you currently in pain? Y N

Have you experienced any problems associated with previous dental work? Y N

Is there anything about having dental treatment that bothers you? Y N
 (If yes, please explain) _____

Have you ever been instructed in the prevention of decay? Y N

Have you ever been instructed in caring for your gums? Y N

Do your gums bleed while brushing or flossing? Y N

How often do you floss your teeth? _____

Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? Y N

Do you experience any breath malodor/halitosis? Y N

Do you now or have you ever experienced pain/discomfort in your jaw joint/TMJ? Y N

Have you had any head, neck or jaw injuries? Y N

Do you clench or grind your teeth while awake or sleeping? Y N

Do you have any lumps or sores in or near your mouth? Y N

Do you bite your cheeks frequently? Y N

Have you ever had the following:

1. Orthodontic treatment (braces) Y N

2. Oral Surgery/tooth extraction Y N

3. Gum Disease/Gum Treatment Y N

4. Bite Appliance/Night guard Y N

Do you participate in sports or activities that have the potential to damage your teeth or jaw?
 If yes, please list: _____



If you could change anything about your smile, what would it be?

Are there old fillings or dental work you don't like looking at?
If so, please explain: _____

Would you be interested in viewing what your teeth would look like after whitening? Y N

Would you be interested in viewing what your mouth would look like with only tooth-colored fillings? Y N

On a scale of 1 to 10, where does your health/oral health rate in comparison with all of your other priorities?

1 2 3 4 5 6 7 8 9 10
Lowest Highest

Why did you leave your last dentist?

What are your expectations of us?

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me, to third party payors and/or other practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am responsible for payment of services rendered and agree to pay any copayment and deductibles that my insurance does not cover.

For your convenience, we offer the following payment options.

Please check the option which you prefer:

- Cash
- Personal Check
- Credit Card
- Visa MasterCard Discover American Express

Signature: _____

Date: ____/____/____

Belmont Dental Care

3344 North Lincoln, Chicago, Illinois 60657

Phone: (773) 549-7971 Fax: (773) 348-7544

Dental Info. Con't