Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Date ______

Cell # ______

Name ______

Soc. Sec. # ______ Birthdate ______ Home Phone ______

Address ______ City ______ State ______ Zip ______

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

E-mail address ______

Patient's or Parent's Employer ______ Work Phone ______

Business Address ______ City ______ State ______ Zip ______

Spouse or Parent's Name ______ Employer ______ Work Phone ______

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 ______

Drivers License # ______ Birthdate ______ Financial Institution ______

Employer ______ Work Phone ______ SSN# ______

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 ______ Union or Local # ______ Work Phone ______

Employer Address ______ City ______ State ______ Zip ______

Insurance Company ______ Group # ______ Policy/ID# ______

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 ______ Union or Local # ______ Work Phone ______

Employer Address ______ City ______ State ______ Zip ______

Insurance Company ______ Group # ______ Policy/ID# ______

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
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain ______________	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? ______________	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (eg. nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other ______________	☐	☐

9. Women Only:	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other ______________	☐	☐

Patient Dental History

Name of Previous Dentist and Location ______________ Date of Last Exam ______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement ______________	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

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.

X ______________

Signature of patient (or parent if minor)

Doctor's Comments ______________

____

Signature ______________ Date ______________

Chicago Osteopathic Hospital Dental Clinic, P.C.
1525 East 53rd street, Ste. 522~Chicago, Illinois 60615
Phone (773) 947-4665~Fax (773) 256-2373

Consent For Treatment

Patient's Name:____________________ **Chart #________**

- **I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of patient above mentioned dental needs.**
- **upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.**
- **I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for complete recital of any possible complications.**
- **I agree to be responsible for payment of all services rendered on my behalf or my dependents.**
- **I understand that payment is due at the time of service unless other arrangements have been made prior to my dental work being started.**
- **I authorize and request my dental insurance company to pay directly to Chicago Osteopathic Hospital Dental Clinic, P.C.**
- **I understand that my dental insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services performed on my behalf or my dependents.**
- **I understand that there is a fee for all BROKEN/FAILED appointments with less than 24 hours notice of cancellation.**

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform Chicago Osteopathic Hospital Dental Clinic, P.C. of any changes in my medical or dental status.

____________________________ ____________
SIGNATURE OF PATIENT/PARENT IF MINOR **DATE**