



**Autumn Dental**

19848 South La Grange Rd. Mokena, IL 60448  
(708) 995-1859

Today's Date: \_\_\_\_\_

**PATIENT INFORMATION**

Name, Last: \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ DOB \_\_\_\_\_

Gender  Male  Female Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status:  Single  Married  
 Divorced  Widowed Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Other # \_\_\_\_\_

Cell # \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work # \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

If Minor, Parent's Name: \_\_\_\_\_ Have you or any member of your family been a patient at this office before?  Yes  No Whom may we thank for recommending our office to you?

\_\_\_\_\_ Otherwise, how did you learn about our practice?  Insurance  Internet  
 Mailer  Radio  Community Event  Other: \_\_\_\_\_

**ACCOUNT RESPONSIBLE PARTY**

Person Responsible for Account: \_\_\_\_\_

Currently a patient in our office(s)?  Yes  No Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ DOB: \_\_\_\_\_

Driver's License: \_\_\_\_\_ State: \_\_\_\_\_ Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Email: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Member ID: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Phone # \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Group or Policy # \_\_\_\_\_ Union/Group Name: \_\_\_\_\_

## DENTAL HISTORY

What is the primary reason for your dental visit today?

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Are you aware of any dental problems? If so, please explain:

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Please check any of the following problems that apply to you:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Sensitivity (hot, cold, sweets) | <input type="checkbox"/> Bleeding, swollen or irritated gums | <input type="checkbox"/> Tooth pain when chewing  |
| <input type="checkbox"/> Teeth or filling breaking       | <input type="checkbox"/> Loose, tipped or shifting teeth     | <input type="checkbox"/> Dry Mouth                |
| <input type="checkbox"/> Jaw Joint Pain                  | <input type="checkbox"/> Bad Breath or bad taste in mouth    | <input type="checkbox"/> Grinding/Clenching teeth |

If you could whiten your teeth for a cost you could afford would you do it?  Yes  No

If you could change anything about your smile it would be:

- |   |   |
|---|---|
| <input type="checkbox"/> Make them brighter       | <input type="checkbox"/> Make them straighter                               |
| <input type="checkbox"/> Close spaces             | <input type="checkbox"/> Replace metal fillings with tooth colored fillings |
| <input type="checkbox"/> Repair chipped teeth     | <input type="checkbox"/> Replace missing teeth                              |
| <input type="checkbox"/> Alternative to a denture | <input type="checkbox"/> Replace old crowns that don't match                |
| <input type="checkbox"/> Get a smile makeover     | <input type="checkbox"/> Other _____  |

## MEDICAL HISTORY

Please check any of the following that APPLIES TO THE PATIENT:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Pre-Med-Amox                                  | <input type="checkbox"/> Pre- Med- Clind     | <input type="checkbox"/> Pre- Med- Other                            | <input type="checkbox"/> Anemia                  |
| <input type="checkbox"/> Allergy                                       | <input type="checkbox"/> Allergy-Medications | <input type="checkbox"/> Alzheimer's/Dementia                       | <input type="checkbox"/> Artificial Joints       |
| <input type="checkbox"/> Arthritis                                     | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blood Disease                              | <input type="checkbox"/> Blood Thinners          |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Dizziness/Fainting                         | <input type="checkbox"/> Epilepsy/Seizures       |
| <input type="checkbox"/> Excessive Bleeding                            | <input type="checkbox"/> Gastric Disorders   | <input type="checkbox"/> Glaucoma                                   | <input type="checkbox"/> Head Injuries           |
| <input type="checkbox"/> Heart Attack/ Stroke                          | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Heart Murmur/MVP                           | <input type="checkbox"/> Hepatitis               |
| <input type="checkbox"/> HIV/Aids                                      | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Liver Disease                              | <input type="checkbox"/> Blood Pressure High/Low |
| <input type="checkbox"/> Nervous Disorders                             | <input type="checkbox"/> Osteoporosis Meds   | <input type="checkbox"/> Other                                      | <input type="checkbox"/> Pacemaker/Stents        |
| <input type="checkbox"/> Psychiatric Care                              | <input type="checkbox"/> Radiation/Chemo     | <input type="checkbox"/> Respiratory Problems                       | <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Rheumatism                                    | <input type="checkbox"/> Sinus Problems      | <input type="checkbox"/> Tuberculosis                               | <input type="checkbox"/> Tumors/Growths          |
| <input type="checkbox"/> Venereal Disease                              | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Anxiety/Depression                         | <input type="checkbox"/> Thyroid disease         |
| <input type="checkbox"/> Seizures                                      | <input type="checkbox"/> Latex Allergy       | <input type="checkbox"/> Taking birth control                       | <input type="checkbox"/> Nursing                 |
| <input type="checkbox"/> Recent Hospitalization (illness or injury)    |  | <input type="checkbox"/> Subject to frequent headaches or migraines |  |
| <input type="checkbox"/> Presently being treated for any other illness |  | <input type="checkbox"/> Tobacco/Alcohol Use                        |  |
| <input type="checkbox"/> Pregnant/Planning Pregnancy                   |  | <input type="checkbox"/> Diagnosed with Osteoporosis                |  |

Do you use any recreational drugs?  Yes  No Which drugs? \_\_\_\_\_

What medical conditions are you currently being treated for? \_\_\_\_\_

Physicians name: \_\_\_\_\_ Phone # \_\_\_\_\_

Please list any **Medications** you are currently taking: \_\_\_\_\_

\_\_\_\_\_

Please list any medications you are **Allergic** to or have bad reactions to: \_\_\_\_\_

*To the best of my knowledge, I have answered every question completely and accurately. It is my responsibility to inform the dental office of any changes in my health and or medications.*

**Patient or Guardian signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **HIPAA Acknowledgment**

I understand that I may inspect or copy the protected health information described in this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be as effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

**I authorize this dental practice to release any financial or dental information to the following person(s) listed:**

\_\_\_\_\_

**Signature**\_\_\_\_\_