About You

Date: _____/_____/_____

Last Name:	First:	M.I.	☐MR. ☐MRS . ☐MS. ☐DR.
I prefer to be called:			Gender: ☐Male ☐Female
Marital status: *(Please select one)* ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated			
Birthdate: / /	Age:	SS#	
Home Address:	City:	State:	Zip:
E-Mail Address:	Home #: ( ) -	Cell # ( ) -	
Work # ( ) -	Ext.		
Employer:	Employer's Address:		
How long there?	Occupation:		
Where and when are the best times to reach you?			
Whom may we thank for referring you?			
Other family members seen by us:			
Previous / Present Dentist:			
Last dental visit date:			

SPOUSE INFORMATION

Last Name:	First:	M.I.	☐MR. ☐MRS . ☐MS. ☐DR.
Birthdate: / /	Age:	SS#	
Employer:	Work # ( ) -	Ext.	
Person Responsible for Account:	Relation:		
Billing Address:	City:	State:	Zip:
Employer:	SS#		

INSURANCE INFORMATION

PRIMARY COVERAGE	Dental Coverage: ☐YES ☐NO		
Insurance Company:		Ph #: ( ) -	
Insurance Address:	City:	State	Zip
Group # (Plan, Local or Policy #):	Insured's ID #		
Insured's Employer:	Insured's Name:		
Relation:	Insured's Birthday: _____/_____/_____		

SECONDARY COVERAGE

SECONDARY COVERAGE	Dental Coverage: ☐YES ☐NO		
Insurance Company:		Ph #: ( ) -	
Insurance Address:	City:	State	Zip
Group # (Plan, Local or Policy #):	Insured's ID #		
Insured's Employer:	Insured's Name:		
Relation:	Insured's Birthday: _____/_____/_____		

EMERGENCY INFORMATION

In the event of an emergency, is there someone who lives close to you that we should contact?		
His / Her name:	Relation:	
Home #: ( ) -	Cell # ( ) -	Work # ( ) - Ext.

Gentle Family Dentistry of Naperville
10 E. Benton Ave., Naperville, IL 60540
Phone: (630) 355-0100 | Fax: (630) 355-0572 | Email: info@naperdent.com

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Do you have a personal physician? ☐YES ☐NO	Date of last visit:		
Physician's Name:		Ph #: ( ) -	
Are you under a physician's care now?	☐YES ☐NO	If yes, please explain:	
Are you taking any medications, pills or drugs?	☐YES ☐NO	If yes, please explain:	
Have you ever been hospitalized or had a major operation?	☐YES ☐NO	If yes, please explain:	
Have you ever had a serious head or neck injury?	☐YES ☐NO	If yes, please explain:	
Have you taken Fosamax, or any other bisphosphonate	☐YES ☐NO	If yes, please explain:	
Do you take, or have you taken Phen-Fen or Redux?	☐YES ☐NO	If yes, please explain:	
Are you on a special diet?	☐YES ☐NO	If yes, please explain:	
Do you smoke or use tobacco?	☐YES ☐NO	If yes, please explain:	
Do you use controlled substances?	☐YES ☐NO	If yes, please explain:	
Are you pregnant or trying to get pregnant?	☐YES ☐NO	If yes, please explain:	
Are you taking oral contraceptives?	☐YES ☐NO	If yes, please explain:	
Are you nursing	☐YES ☐NO	If yes, please explain:	

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? ☐**Aspirin** ☐**Penicillin** ☐**Codeine** ☐**Local Anesthetics** ☐**Metal** ☐**Latex** ☐**Acrylic** ☐**SULFA**

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?:

AIDS HIV Positive	☐YES	☐NO	Excessive Thirst	☐YES	☐NO	Pain in the Jaw Joints	☐YES	☐NO
Alzheimers	☐YES	☐NO	Fainting Spells / Dizziness	☐YES	☐NO	Parathyroid Disease	☐YES	☐NO
Anaphylaxis	☐YES	☐NO	Frequent Cough	☐YES	☐NO	Psychiatric Care	☐YES	☐NO
Anemia	☐YES	☐NO	Frequent Diarrhea	☐YES	☐NO	Radiation Treatments	☐YES	☐NO
Angina	☐YES	☐NO	Frequent Headaches	☐YES	☐NO	Recent Weight Loss	☐YES	☐NO
Arthritis/Gout	☐YES	☐NO	Genital Herpes	☐YES	☐NO	Renal Dialysis	☐YES	☐NO
Artificial Heart Valve	☐YES	☐NO	Glaucoma	☐YES	☐NO	Rheumatic Fever	☐YES	☐NO
Artificial Joint	☐YES	☐NO	Hay Fever	☐YES	☐NO	Rheumatism	☐YES	☐NO
Asthma	☐YES	☐NO	Heart Attack/Failure	☐YES	☐NO	Scarlet Fever	☐YES	☐NO
Blood Disease	☐YES	☐NO	Heart Murmur	☐YES	☐NO	Shingles	☐YES	☐NO
Blood Tranfusion	☐YES	☐NO	Heart Pace Maker	☐YES	☐NO	Sickle Cell Disease	☐YES	☐NO
Breathing Problem	☐YES	☐NO	Heart Trouble/Disease	☐YES	☐NO	Sinus Trouble	☐YES	☐NO
Bruise Easily	☐YES	☐NO	Hemophilia	☐YES	☐NO	Spinal Bifida	☐YES	☐NO
Cancer	☐YES	☐NO	Hepatitis A	☐YES	☐NO	Stomach/Intestinal Disease	☐YES	☐NO
Chemotherapy	☐YES	☐NO	Hepatitis B or C	☐YES	☐NO	Stroke	☐YES	☐NO
Chest Pains	☐YES	☐NO	Herpes	☐YES	☐NO	Swelling of Limbs	☐YES	☐NO
Cold Sores/Fever Blisters	☐YES	☐NO	High Blood Pressure	☐YES	☐NO	Thyroid Disease	☐YES	☐NO
Congenital Heart Disorder	☐YES	☐NO	Hives or Rash	☐YES	☐NO	Tonsilitis	☐YES	☐NO
Convulsion	☐YES	☐NO	Hypoglycemia	☐YES	☐NO	Tuberculosis	☐YES	☐NO
Cortisone Medication	☐YES	☐NO	Irregular Heartbeat	☐YES	☐NO	Tumors or Growths	☐YES	☐NO
Diabetes	☐YES	☐NO	Kidney Problems	☐YES	☐NO	Ulcers	☐YES	☐NO
Drug Addiction	☐YES	☐NO	Leukemia	☐YES	☐NO	Venereal Disease	☐YES	☐NO
Easily Winded	☐YES	☐NO	Liver Disease	☐YES	☐NO	Yellow Jaundice	☐YES	☐NO
Emphysema	☐YES	☐NO	Low Blood Pressure	☐YES	☐NO			
Epilepsy or Seizures	☐YES	☐NO	Lung Disease	☐YES	☐NO			
Excessive Bleeding	☐YES	☐NO	Mitral Valve Prolapse	☐YES	☐NO			

Have you ever had any serious illness not listed above? ☐YES ☐NO If yes, please explain:_____

Comments_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes to medical status.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also repsonsible for paying any co-payment and deductible that my insurance does not cover.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.
I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.
Signature of patient: (Parent or Guardian if minor)X_____ Date_____