

# About You

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name:		First:	M.I.	<input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS. <input type="checkbox"/> DR.	
I prefer to be called:				Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital status: <i>(Please select one)</i> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated					
Birthdate: / /		Age:	SS#		
Home Address:			City:	State:	Zip:
E-Mail Address:			Home #: ( ) -	Cell # ( )	-
Work # ( ) - Ext.					
<b>Employer:</b>			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.	<input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS. <input type="checkbox"/> 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: <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> YES <input type="checkbox"/> 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**

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## 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date of last visit:
Physician's Name:		Ph #: (   )   -
Are you under a physician's care now?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please explain:
Are you taking any medications, pills or drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please explain:
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please explain:
Have you ever had a serious head or neck injury?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please explain:
Have you taken Fosamax, or any other bisphosphonate	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please explain:
Do you take, or have you taken Phen-Fen or Redux?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please explain:
Are you on a special diet?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please explain:
Do you smoke or use tobacco?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please explain:
Do you use controlled substances?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please explain:
Are you pregnant or trying to get pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please explain:
Are you taking oral contraceptives?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please explain:
Are you nursing	<input type="checkbox"/> YES <input type="checkbox"/> 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	Excessive Thirst	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pain in the Jaw Joints	<input type="checkbox"/> YES <input type="checkbox"/> NO
Alzheimers	<input type="checkbox"/> YES <input type="checkbox"/> NO	Fainting Spells / Dizziness	<input type="checkbox"/> YES <input type="checkbox"/> NO	Parathyroid Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Anaphylaxis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Cough	<input type="checkbox"/> YES <input type="checkbox"/> NO	Psychiatric Care	<input type="checkbox"/> YES <input type="checkbox"/> NO
Anemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Diarrhea	<input type="checkbox"/> YES <input type="checkbox"/> NO	Radiation Treatments	<input type="checkbox"/> YES <input type="checkbox"/> NO
Angina	<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Headaches	<input type="checkbox"/> YES <input type="checkbox"/> NO	Recent Weight Loss	<input type="checkbox"/> YES <input type="checkbox"/> NO
Arthritis/Gout	<input type="checkbox"/> YES <input type="checkbox"/> NO	Genital Herpes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Renal Dialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Heart Valve	<input type="checkbox"/> YES <input type="checkbox"/> NO	Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatic Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Joint	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hay Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rheumatism	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Attack/Failure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Scarlet Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Murmur	<input type="checkbox"/> YES <input type="checkbox"/> NO	Shingles	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Tranfusion	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Pace Maker	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sickle Cell Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Breathing Problem	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Trouble/Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sinus Trouble	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bruise Easily	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hemophilia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Spinal Bifida	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis A	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stomach/Intestinal Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chemotherapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis B or C	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chest Pains	<input type="checkbox"/> YES <input type="checkbox"/> NO	Herpes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Swelling of Limbs	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cold Sores/Fever Blisters	<input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Congenital Heart Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hives or Rash	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tonsilitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Convulsion	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hypoglycemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cortisone Medication	<input type="checkbox"/> YES <input type="checkbox"/> NO	Irregular Heartbeat	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tumors or Growths	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ulcers	<input type="checkbox"/> YES <input type="checkbox"/> NO
Drug Addiction	<input type="checkbox"/> YES <input type="checkbox"/> NO	Leukemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Venereal Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Easily Winded	<input type="checkbox"/> YES <input type="checkbox"/> NO	Liver Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Yellow Jaundice	<input type="checkbox"/> YES <input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES <input type="checkbox"/> NO	Low Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Epilepsy or Seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO	Lung Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Excessive Bleeding	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mitral Valve Prolapse	<input type="checkbox"/> YES <input type="checkbox"/> 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 responsible 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 \_\_\_\_\_