Bucktown Wicker Park Dental

Enhancing Beauty Advancing Health

Welcome to Bucktown Wicker Park Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age ____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account Name _____

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

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Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no whether you have had any of the following:

___ Bad Breath _____ Food collection between teeth ___ periodontal treatment ___ Sensitivity to sweets

___ Bleeding gums ___ Grinding or clenching teeth ___ Sensitivity to cold ___ Sensitivity when biting ____

___ Clicking or popping jaw ____ Loose teeth or broken fillings ____ Sensitivity to hot ____ Sores or growths in mouth

How often do you brush? _____ Electric or Manual toothbrush? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ____

Other information about your dental health or previous treatment_____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illness or operations? Y or N

If yes, describe _____

Are you currently under Physician care? Y or N If yes, describe _____

Have you ever has a blood transfusion? Y or N If yes, give approximate dates _____

Have you ever taken Fen- Phen/Redux? Y or N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva Y or N

Woman: Are you pregnant? Y or N Nursing? Y or N Taking Birth Control pills? Y or N

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HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS

Y N	AIDS/HIV Positive	Y N	Cough, persistent	Y N	Jaw Pain	Y N	Shingles
Y N	Anaphylaxis	Y N	Cough up blood	Y N	Kidney disease	Y N	Shortness of breath
Y N	Anemia	Y N	Diabetes	Y N	Liver disease	Y N	Spina Bifida
Y N	Arthritis, Rheumatism	Y N	Epilepsy	Y N	Material allergies	Y N	Stroke
Y N	Artificial heart valves	Y N	Fainting	Y N	Mitral Valve prolapse	Y N	Swelling of feet /ankle
Y N	Artificial joints	Y N	Food Allergies	Y N	Nervous problems	Y N	Thyroid disease
Y N	Asthma	Y N	Glaucoma	Y N	Pace maker	Y N	Heart surgery
Y N	Atopic	Y N	Headaches	Y N	Psychiatric care	Y N	Tobacco Habit
Y N	Back problems	Y N	Heart murmur	Y N	Rapid weight gain or loss	Y N	Tonsillitis
Y N	Cancer	Y N	Heart problems	Y N	Radiation treatment	Y N	Tuberculosis
Y N	Chemical dependency	Y N	Hemophilia	Y N	Respiratory disease	Y N	Ulcer/Colitis
Y N	Circulatory problems	Y N	Herpes	Y N	Rheumatic/ Scarlet fever	Y N	Venereal disease
Y N	Chemotherapy	Y N	Cortisone treatments	Y N	Hepatitis	Y N	High blood pressure
Y N	Frequent Headaches	Y N	Trouble falling asleep	Y N	Ringing in ears	Y N	Trouble staying asleep

Please list any serious medical conditions that you have ever had: _____

Are you currently taking any medications? If yes, list all:_____

Do you have any drug allergies? If yes, list all: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all changes whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.