

Wheaton Cosmetic Dentistry

1275 E. Butterfield Rd., #202

Phone: 630-653-5152

Fax: 630-653-5380

Patient Information

Name _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
E-Mail _____ Home Phone _____ Date of Birth _____
Work Phone _____ Cell Phone _____ Drivers License # _____
Social Security # _____ Minor _____ Single _____ Married _____
Divorced _____
Patient's or Parent's Employer Name _____ Work Phone # _____
Business Address _____ City _____ State _____ Zip _____
Person to contact in case of emergency _____ Phone _____

WHO MAY WE THANK FOR REFERRING YOU?

Responsible Party (Only fill out if different than above)

Name of Person Responsible for this Account _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Birth date _____
Social Security # _____ Employer _____
Business Address _____ City _____ State _____ Zip _____

Dental Insurance Information (This information is for the subscriber – not necessarily the patient)

Name of Insured _____ Relationship _____
Birth date _____ Social Security # _____ Work Phone _____
Name of Employer _____ Employer Address _____
City _____ State _____ Zip _____
Dental Insurance Company _____ Group# _____ /ID _____
Insurance Phone # _____ Insurance Address _____
City _____ State _____ Zip _____
How much is the: Deductible? _____ Yearly Max _____ How much has been used this year? _____

CONSENT: The undersigned patient hereby authorizes the Doctor to take x-rays or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. Patient authorizes the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. Patient acknowledges and accepts the risk associated with anesthetic agents. Patient shall pay for all treatment(s) incurred, with or without the Patient's signature. In the event that the patient fails to make payment when due, Patient shall pay, in addition to the invoice amount, a late charge of 1 ½ percent per month. Late payment charges shall be construed in such a manner as to be enforceable under the pertinent state law (including but not limited to classification as "interest" and liquidated damages"). Patient agrees to pay all cost of collection by the Doctor of any amounts due hereunder, including actual attorney's fees. If patient is a minor, the parent or guardian of the minor agrees to be responsible for all treatment(s) received by a minor. If a credit card is provided, Patient authorizes Doctor to apply all past due amounts to the credit card provided. Patient agrees to assign all dental insurance benefits to the Doctor.

VISA MC DISCOVER AMEX _____ exp date _____ Security Code _____

Patient Signature (Parent if Child) _____
Date ____/____/____

Dentist Signature _____
Date ____/____/____

Name _____

Medical

Physician _____ Phone # _____ Date of last exam _____
Yes No Yes

- | | |
|---|--|
| <p>No</p> <p>1. Are you under medical treatment now? _____</p> <p>2. Have you ever been hospitalized for any operation or serious illness? If yes, please explain: _____
_____</p> <p>3. Are you taking any medications including non-prescription medications? Please list: _____

_____</p> <p>4. Have you ever taken Phen-Fen/Redux? _____</p> <p>5. Do you use tobacco? _____</p> <p>6. Do you use controlled substances? _____</p> <p>7. Are you wearing contact lenses? _____</p> <p>8. Are you pregnant or think you might be? _____</p> <p>9. Please check all that apply:</p> | <p>10. Are you allergic to or have you had any reactions to the following?</p> <p>Local Anesthetics (Novocain) _____</p> <p>Latex _____</p> <p>Penicillin or any antibiotic _____</p> <p>Sulfa drugs _____</p> <p>Barbiturates _____</p> <p>Sedatives _____</p> <p>Iodine _____</p> <p>Aspirin _____</p> <p>Metals (nickel, mercury) _____</p> <p>Other: _____</p> <p>11. Are you taking oral contraceptives? _____</p> <p>12. Are you nursing? _____</p> <p>13. Do you take an aspirin daily? _____</p> |
|---|--|

	Yes	No	Yes	No	Yes	No	
Aids/HIV infection	___	___	Emphysema/Winded	___	___	Implant	___
Allergies/Hay Fever	___	___	Epilepsy/Convulsions	___	___	Joint Replacement	___
Anemia	___	___	Fainting/Seizures	___	___	Kidney Disease	___
Angina/Chest Pain	___	___	Glaucoma	___	___	Leukemia	___
Arthritis	___	___	Heart Attack	___	___	Liver Disease	___
Asthma	___	___	Heart Disease/Defect	___	___	Low Blood Pressure	___
Cancer	___	___	Heart Murmur	___	___	Mitral Valve Prolapse	___
Cardiac Pacemaker	___	___	Hepatitis/Jaundice	___	___	Osteoporosis	___
Diabetes	___	___	High Blood Pressure	___	___	Radiation Therapy	___
Recent Weight Loss	___	___	Respiratory Problems	___	___	Rheumatic Fever	___
STD	___	___	Ulcer/Gurd	___	___	Swollen Ankles	___
Thyroid Problems	___	___	Tuberculosis	___	___	Stroke	___
Abnormal bleeding	___	___	Alcohol/drug abuse	___	___	Artificial valves	___
Chemotherapy	___	___	Lupus	___	___	Psychiatric treatment	___
Blood transfusion	___	___	Herpes	___	___	Cold sores/fever blisters	___
Sickle cell	___	___	Shingles	___	___	Hemophilia	___
Steroid therapy	___	___	Other	___	___		___

Dental

Previous Dentist _____ Phone # _____ Last Cleaning/Exam _____

	Yes	No	Yes	No	
1. Do your gums bleed while brushing/ flossing?	___	___	___	___	
2. Are your teeth sensitive to hot or cold?	___	___	___	___	
3. Have you ever been diagnosed with gum/periodontal disease?	___	___	___	___	
4. Do you feel pain in any of your teeth?	___	___	___	___	
5. Do you have any sores/lumps in mouth?	___	___	___	___	
6. Have you had head, neck or jaw injuries?	___	___	___	___	
7. Have you experienced the following problems in your jaw?					
Clicking	___	___	___	___	
Pain (joint, ear, side of face)	___	___	___	___	
Difficulty opening/closing your mouth	___	___	___	___	
Difficulty in chewing	___	___	___	___	
8. Have you ever required antibiotics before dental treatment?	___	___	___	___	
9. Do you have frequent headaches?			___	___	
10. Do you clench or grind your teeth?			___	___	
11. Do you bite your lips or cheeks?			___	___	
12. Have you ever had treatment for periodontal disease?			___	___	
13. Have you had a difficult extraction?			___	___	
14. Have you had prolonged bleeding after an extraction?			___	___	
15. Have you had orthodontics?			___	___	
16. Do you wear dentures or partials?			___	___	
If yes, date of placement _____					
17. Have you received oral hygiene instructions on gum/teeth care?			___	___	
18. 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/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.**

Your Signature X _____ Date _____