Dental Care
Providers of America

Welcome to our practice!

Thank you for selecting us to be your dental team. Please fill out this form completely and to the best of your knowledge. Print clearly. If you have any concerns or questions about this form ask for assistance from our friendly staff.

Name: ______________________________ Birth Date: __________ Gender: M F
(First) (Last) (Middle)

Home Address: ______________________ City: ______________ State: ____ ZIP: ______
Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________
Email: ______________________________ Soc. Sec. #: ______________________
Please Check: Single ______ Married ______ Separated ______ Widowed ______ Divorced ______

Employer: ______________________________ Occupation: ______________________
Business Address: ______________________ City: ______________ State: ____ ZIP: ____
Spouse/Guardian Name: ______________________ Work or Cell Phone: ______________
Person to contact in case of emergency: ______________________ Phone: ______________

We are always grateful for a referral. Whom may we thank for referring you? ______________

Responsible Party for this account (if different from above)
Name: ______________________________ Relationship: ______________
Address: ______________________________ Phone: ______________
City: ______________________ State: ______ ZIP: ________ Soc.Sec #: ______________

Primary Insurance
Group #: ______________________ Subscriber: ______________________ ______________
Insurance Company: ______________________ Subscriber D.O.B: ______________

Secondary Insurance
Group #: ______________________ Subscriber: ______________________ ID#: ______________
Insurance Company: ______________________ Subscriber D.O.B: ______________

Office Policies

Payment in full is expected at the time services are rendered. For patients with insurance you must pay your entire co-pay at the time of the treatment visit. By signing below, you authorize direct payment of dental benefits otherwise payable to you, to Dental Care of Vernon Hills. Any insurance claims that are denied or remain unpaid at 30 days are considered past due. If you wish to make special payment arrangements you must speak to the office manager. We accept Visa/Mastercard/AMEX/Discover, Cash, Check, Debit, Care Credit, and Chase Advance. There is a fee of $25 for all returned checks. Delinquent accounts may be sent to collection agency and collection fees may apply. By missing an appointment you block other patients from getting treatment. You will be charged $50 for each appointment that you do not call to reschedule at least 24 hours in advance of the appointment time. Any patient missing more than 2 appointments in a 12 month period may not be allowed to reschedule.

Sign: ______________________________________ Date: ______________

Dental History

Previous Dentist:________________________________ Date of Last Exam:____/____/_____

	Yes	No
Are you having any dental problems that you are aware of?..........	☐	☐
Do you have a history of gum disease?..........	☐	☐
Do you have any clicking, popping or discomfort in jaw joints?..........	☐	☐
Do you feel nervous about dental treatment?..........	☐	☐
Have you ever had a bad experience in a dental office..........	☐	☐
Have you ever had any complications after dental treatment?..........	☐	☐
Are you happy with your smile?..........	☐	☐
Would you like whiter teeth?..........	☐	☐

Medical History

Current Physician: ________________________________ Date of Last Exam:____/____/_____

	Yes	No
Are you currently under a physician's care for any reason?..........	☐	☐
Have you been hospitalized in the last two years for any reason?..........	☐	☐
Have you taken any prescription medications in the last two years?..........	☐	☐
Are you currently anking any vitamins, herbal supplements or "cures"..........	☐	☐
Are you on a special diet? (explain) ____________________	☐	☐
Do you smoke or chew tobacco? (years)__________ (packs per day)__________	☐	☐
Do you use recreational drugs (marijuana, cocaine, methamphetamine)?..........	☐	☐

Do you consume alcohol? Daily Weekly Within last 24 hours

Do you have any drug/substance allergies?(list)________________________________

Please list current medications:

____

Preferred Pharmacy: ________________________________ Phone: ____________________

Women Only: Oral contraceptive Y N Nursing Y N Pregnant Y N Due Date:__________

Do you have or have you had any of the health problems listed below?

	Yes	No		Yes	No		Yes	No
Heart Disease	☐	☐	Artificial Joints	☐	☐	Emphysema	☐	☐
Irregular Heartbeat	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐
Angina/Chest Pains	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐
Heart Attack	☐	☐	Sickle Cell Disease	☐	☐	Radiation Treatments	☐	☐
Artificial Heart Valve	☐	☐	Blood Disorder	☐	☐	Chemotherapy	☐	☐
Cardiac Pace Maker	☐	☐	Leukemia	☐	☐	Stomach Ulcers	☐	☐
Heart Surgery	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Change	☐	☐
High Blood Pressure	☐	☐	Lung Disease	☐	☐	Diabetes	☐	☐
Kidney Problems	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐
HIV Positive	☐	☐	Frequent Cough	☐	☐	Liver Disease	☐	☐
Drug Addiction	☐	☐	Asthma	☐	☐	Hep A, B, or C	☐	☐
Seasonal Allergies	☐	☐	Epilepsy or Seizures	☐	☐	Psychiatric Care	☐	☐

I have answered every question to the best of my knowledge. I understand improper information can be dangerous to my safety during dental treatment. I consent to complete oral examination and necessary x-rays.

Sign: ________________________________ Date: ____________________