PATIENT INFORMATION

PLEASE COMPLETE THE FOLLOWING INFORMATION

1. PATIENTS LAST NAME_____
2. PATIENTS FIRST NAME_____
3. SEX_____
4. BIRTHDAY MM/DD/YY_____
5. SSN_____
6. STREET ADDRESS_____
7. CITY, STATE_____
8. ZIPCODE_____
9. HOME PHONE_____
10. CELL PHONE_____
11. EMAIL ADDRESS_____

FINANCIALLY RESPONSIBLE PERSON (IF NOT YOURSELF)

1. LAST NAME_____
2. FIRST NAME_____
3. BIRTHDAY MM/DD/YY_____
4. SEX _____
5. SSN_____
6. STREET ADDRESS_____
7. CITY, STATE_____
8. ZIPCODE_____
9. HOME PHONE_____
10. CELLPHONE_____
11. EMAIL ADDRESS_____

COMPLETE THE FOLLOWING IF YOU HAVE DENTAL INSURANCE

1. EMPLOYER OR COLLEGE_____
2. EMPLOYERS OR COLLEGE ADDRESS_____
3. WORK PHONE_____
4. INSURANCE COMPANY_____
5. INSURANCE COMPANY PHONE_____
6. GROUP NUMBER_____
7. LOCAL UNION NUMBER(IF ANY)_____
8. EMPLOYEE I.D. # IF DIFFERENT THAN SS#_____
9. SECOND INSURANCE COMPANY (IF ANY)_____

How will you be paying for services?

_____Cash _____Check

_____MasterCard/Visa/Discover _____Insurance consignment

Persons paying by check, insurance or M/C/Visa/Discover will be required to present I.D

REFERRED BY: _____

Would like to be contacted for recalls by ____Mail _____Email

_____Text(Please put carrier_____)Example AT&T, Sprint, Verizon…..Etc

Park Avenue Dental **MEDICAL AND DENTAL HISTORY**

Today's Date____/____/____ Date of Birth____/____/____

Name_____ YES NO

1. Are you in good health? ____ ____
2. Has there been any change in your general health within the past year? ____ ____
3. Date of last physical examination _____
4. Are you now under the care of a physician or health care professional? ____ ____
5. If so, what is the condition being treated? _____
6. Name and address of physician_____

   _____Phone No._____
7. Have you had any serious illness, operation, or been hospitalized in the past five years? ____ ____
8. If so, what was the problem? _____
9. FEMALES ONLY: Are you pregnant? Y or N Do you take oral contraceptives? Y or N
10. CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

SKIN
__Itching
__Rash/hives
__Ulcers
__Shingles
__Pigmentation/skin color changes
__Lack or loss of body hair
__Other

EYES/EARS/NOSE/THROAT
__Visual change/blurring
__Glaucoma
__Loss of hearing
__Ringing in ears
__Frequent ear infections
__Frequent nose bleeds
__Sinus problems
__Frequent sore throat/hoarseness
__Other

HEART/BLOOD VESSELS
__Rheumatic fever
__Heart murmur
__Chest pain
__Heart attack
__Stroke
__Shortness of breath
__Swelling of ankles
__High/low blood pressure
__Congenital heart disease
__Prosthetic valves
__Heart surgery
__Pacemaker
__Vascular diseases
__Anemia
__Other_____

BONE/MUSCLES/JOINTS
__Bone deformity/fracture
__Arthritis/rheumatism
__Artificial joint
__Muscle weakness/pain
__Osteoporosis/Osteopenia
__Other

DIGESTIVE SYSTEM
__Hepatitis/Liver disease
__Jaundice
__Ulcers
__Change in appetite
__Black or bloody stools
__Other_____

GENITOURINARY
__Kidney disease
__Kidney transplant/dialysis
__Difficulty/pain on urination
__Blood in urine
__Frequent urination
__Sexually transmitted disease
__Prostate trouble
__Other

BLOOD/LYMPH/IMMUNE
__Easy bruising/excessive bleeding
__Persistent swollen glands
__Blood transfusion
__Hemophilia
__Anemia/sickle cell
__HIV positive/AIDS
__Leukemia
__Spleen problems

GENERAL
__Autoimmune disease
__Weakness/Tire easily
__Night sweats
__Persistent fever

NERVOUS SYSTEM
__Frequent headaches
__Dizziness/fainting
__Epilepsy/seizures/convulsions
__Neuritis/neuralgia
__Parasthesias/numbness/tingling
__Paralysis
__Hydrocephalic shunt
__Other_____

PSYCHIATRIC
__Nervousness
__Irritability
__Depression/excessive worry
__Mental illness
__Other_____

ENDOCRINE (GLANDS)
__Diabetes
__Thyroid trouble/goiter
__Weight change
__Excessive thirst
__Other_____

RESPIRATORY
__Tuberculosis
__Emphysema/bronchitis
__Asthma/wheezing
__Persistent cough
__Other_____

OTHER
__Radiation therapy
__Chemotherapy
__Tumors or growth
__Cancer
__Alcohol use
__Tobacco use
__Chemical dependency
__Vaping
__Marijuana

OVER →

Park Avenue Dental Care

MEDICAL AND DENTAL HISTORY

(Continued)

11. Are you allergic or have experienced any reaction to the following?

__Local anesthetics (e.g., novocaine)
__Penicillin/other antibiotics
__Sulfa drugs
__Barbiturates/sedatives/sleeping pills
__Iodine
__Latex or rubber gloves/dam
__Metals
__Aspirin
__Codeine or other narcotics
__Other_____

12. Do you take any of the following?

__Antibiotics/sulfa drugs
__Blood thinners
__Aspirin
__Blood pressure medication
__Antineoplastics
__Digitalis/other heart drugs
__Nitroglycerin
__Insulin/other diabetes drugs
__Cortisone/steroids
__Medication for thinning bone
__Thyroid medicine
__Antihistamines/allergy medications
__Recreational drugs
__Other medication_____

If yes to any of the above, list name of medication and dosage below:

_____

_____

13. Do you have any disease, condition, or problem not listed above that you should tell the dentist? If so, please explain_____

_____

_____

14. Do you have or have you ever had any of the following?

__Dental pain
__Bleeding gums/periodontal disease
__Blisters/ulcers/cold sores
__Swelling/lumps in mouth
__White coating on tongue/throat
__Problem with tonsils/adenoids
__Clicking/popping jaw
__Difficulty opening/closing jaw
__Pain in or near ears
__Sinus trouble
__Injury to face/jaw
__Surgery to face/jaw
__Loose teeth
__Sensitive teeth
__Clenching/grinding jaw
__Shifting of teeth
__Dissatisfied with appearance of teeth
__Ortho treatments (braces)
__Do you wear dentures or partials

15. Does dental treatment make you nervous? ___Yes ___No

16. Have you had difficulties with past dental treatment? ___Yes ___No

Please explain_____

17. Last dental visit?_____ Were x-rays taken? Y or N

I certify that I have read and understand the above. _____
Signature of patient/Date

FOR COMPLETION BY THE DENTIST

Comments: _____

_____

_____

_____

_____

_____

_____

Dental management considerations: _____

_____

Is medical consultation necessary? __Yes __No

_____

Signature of dentist/Date

PARK AVENUE DENTAL
18040 PARK AVENUE
HOMEWOOD, ILLINOIS 60430

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

[_____], has received a copy of this office's Notice of Privacy Practices

_____
(Signature)

_____
(Date)

Please list any other person(s) that we may speak to regarding your dental health. Please also indicate their relationship to you.

Name	Relationship
_____	
_____	
_____	
_____	

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other(Please Specify)
- ☐ _____

-We will not use your information for fundraising.
-If the event of a breach of unsecured patient history information you will be notified.
-If you pay in full for a service out of pocket, you have the right to request that our office not disclose treatment information for this service to health plan.
-If you need your records they can be sent electronically by email (possible security risks of emailing sensitive information).
Revised March 20, 2014

Patient Medication Information

Name: Date of birth:

Primary Provider:	Contact Information:	Allergies, Medication Allergies:
Medical Conditions, Comments:	Emergency contact: Relationship:	

Medication Name/Dosage	Type of Medication/Dental impact	Reason	Health Care Provider

Special Instructions, Comments: