Welcome to Illini Smiles Dental Care!

To help us better serve you, please fill out this form completely. If you have any questions or need assistance, please ask us and we will help.

Patient Name: _____**Today's Date:** _____

Preferred Name:_____ / □ **Male** □ **Female** / □ **Married** □ **Single** / □ **Child**

Patient's SS#: _____-_____-_____ **Birth Date:** _____/_____/_____**Home Phone:** _____

Patient's Address: _____ **Cell Phone:** _____

City:_____ **Zip code :**_____**Email:** _____

Patient/(or Parent if under 18) : **Employer**_____ **Work #**_____

Employer's Address: _____

Spouse's Name: _____ **Contact Number**:_____

Contact Person (who does not live with you) Name: _____ **Phone Number:** _____

Responsible Party: If patient is a child or under the age of 18 or if another adult is responsible for the account

Name of Person Responsible for Account: _____ **Relationship to Patient**: _____

SS#: _____-_____-_____ **Birth Date**: _____/_____/_____**Home Phone:** _____

Insurance information: **please provide us with your dental insurance card so we may make a copy**

Name of Primary Insured: _____ _**Relationship to Patient**: _____

SS#: _____-_____-_____ **Insured Birth Date:** _____/_____/_____ **Home Phone:** _____

Employer: _____ **Work Phone:** _____

Insurance Company: _____ **Group #** _____ **Policy #:** _____

Illini Smiles Dental Care

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (or parent if under 18)_____, have been offered a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself or your child covered under the Privacy Act other than yourself.

I, (or parent if under 18) _____ _____, **authorize** the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
{Please Print Name} Relationship

_____ _____
{Please Print Name} Relationship

Tell us how you heard about our office? _____

For Office Use Only

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

❑ **Individual refused to sign**

❑ **Communications barriers prohibited obtaining the acknowledgement** ❑ **An emergency situation prevented us from obtaining acknowledgement** ❑ **Other (Please Specify)**

Patient Medical History

Name of Physician: _____ Last Exam: _____ Office Phone: _____

1. Are you under medical treatment now? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
2. Do you smoke tobacco products? ☐ Yes ☐ No
3. Do you use controlled substances? ☐ Yes ☐ No
4. Have you been hospitalized for any surgical operation or serious illness within the last 5 years?
   If yes, please explain:
   _____
   _____

Medications -

Please document all other medications you are currently taking and their purpose:

Do you have or have you had any of the following? Check all that apply:

Allergies:

- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other_____

☐ Aids/HIV
☐ Anemia/Hemophilia
☐ Arthritis
☐ Artificial/joints
- Date_____
- Type_____

☐ Asthma
☐ Blood Disease
☐ Cancer
- Type_____

☐ Currently Pregnant
- Due date_____

☐ Diabetes
- Type_____

☐ Drug Addiction
☐ Epilepsy/Seizures
☐ Excessive Bleeding
☐ Fainting/Dizziness
☐ Glaucoma
☐ Heart attack
☐ Heart Disease
☐ Heart murmur
☐ Hepatitis
☐ High Blood pressure
☐ HPV
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Migraines
☐ Mitral valve prolapse
☐ Nervous Disorders
☐ Nursing
☐ Pacemaker
☐ Physical Disabilities_____
_____
☐ Pre-medication
☐ Psychiatric Care_____
_____
_____
☐ Radiation
☐ Respiratory
☐ Sinus problems
☐ Skin Rash/Hives
☐ Spina Bifida
☐ Stomach problems
☐ TMJ
☐ Thyroid problems
☐ Tuberculosis
☐ Ulcers
☐ Stroke

☐ Other_____
_____
_____
_____

☐ **NONE of the above**

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam or Cleaning _____

1. Have you ever had any complications during/following dental treatment? □ Yes □ No
2. Are your teeth sensitive to hot, cold or sweet liquids/foods? □ Yes □ No
3. Do you have pain in your teeth or a certain tooth? □ Yes □ No
4. Have you ever had clicking or pain in your jaws or difficulty opening or closing? □ Yes □ No
5. Do you have frequent headaches? □ Yes □ No
6. Do you clench or grind your teeth? □ Yes □ No
7. Have you ever had a difficult extraction(s) or prolonged bleeding following an extraction in the past? □ Yes □ No
8. Have you had any orthodontic treatment (braces)? □ Yes □ No
9. Do you like your smile? □ Yes □ No
10. If you could change one thing about your smile or teeth, what would it be? _____

Authorization and Release:

I certify that I have read, answered and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I also authorize the dentist(s) and/or dental office to release any information to third party payers and/or other healthcare practitioners.

Patient/(or Parent if under 18) Signature x_____