



1580 N Northwest Hwy, Suite 300
Park Ridge, IL 60068

All personal information is held in the strictest confidence.

Date _____

Patient Information:

First Name: _____ MI: _____ Last Name: _____ Title: _____

Nickname _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

Birth Date: _____ Age: _____ SS#: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Student: _____ School: _____

Have you been a patient of our practice before: _____

Insurance Information (if different from above):

Who is responsible for this account: _____

First Name: _____ MI: _____ Last Name: _____ Title: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

Birth Date: _____ Age: _____ SS#: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Spouse Name: _____ Occupation: _____

Referral Information:

Who referred you to our office: _____

General Dentist: _____ Phone: _____

Orthodontist: _____ Phone: _____

Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____



Medical History:

Do you have or have you had any of the following?

- Heart attack Yes No
- Heart surgery Yes No
- Irregular heart beat Yes No
- High blood pressure Yes No
- COPD / emphysema Yes No
- Kidney failure / dialysis Yes No
- Hepatitis / liver disease Yes No
- Stroke / CVA Yes No
- Blood clots / DVT / PE Yes No
- Bleeding disorders Yes No
- Seizures / epilepsy Yes No
- Asthma Yes No

- Diabetes Yes No
- Thyroid disease Yes No
- Autoimmune disorders Yes No
- Immune system deficiency Yes No
- Drug / alcohol addiction Yes No
- Anxiety / psychiatric care Yes No
- Painful / clicking jaw joints Yes No
- Cancer / malignancy Yes No

Site: _____

- Chemotherapy Yes No
- Radiation therapy Yes No

- Yes No Have you ever taken drugs to treat osteoporosis (Boniva, Fosamax, Actonel, Zometa, Aredia)?
- Yes No Blood thinners (Coumadin, Plavix, Aspirin, Eliquis, Pradaxa, Xarelto)?
- Yes No Smoke or vape? Quit? Yes No Year: _____
- Yes No Artificial joints (hip / knee / shoulder) ?
- Yes No Artificial heart valve?
- Yes No Pregnant or breastfeeding?

Illnesses or conditions not listed above:

Please list all current medications : (attach a sheet for long lists)

Please list all previous surgeries:

Please list any allergies (e.g. medicines, latex):

Patient Signature: _____

Date: _____

Doctor Signature: _____

Date: _____



Primary Dental Insurance

Insurance Carrier: _____
Name of Insured: _____
Group Name: _____
Group #: _____
ID #: _____
Policy Plan: _____

Primary Medical Insurance

Insurance Carrier: _____
Name of Insured: _____
Group Name: _____
Group #: _____
ID #: _____
Policy Plan: _____

Secondary Dental Insurance

Insurance Carrier: _____
Name of Insured: _____
Group Name: _____
Group #: _____
ID #: _____
Policy Plan: _____

Secondary Medical Insurance

Insurance Carrier: _____
Name of Insured: _____
Group Name: _____
Group #: _____
ID #: _____
Policy Plan: _____



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**MEDICAL INFORMATION RELEASE FORM
(HIPAA FORM)**

Name: _____ Birth Date: _____

Authorize:

I authorize the release of information including the history, examination, diagnosis, and treatment rendered to me, and claims and billing information. This information may be released to:

Spouse: _____

Parents: _____

Children: _____

Other: _____

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages:

Please call: Cell Home

If unable to reach me:

Leave a detailed message

Leave a message asking me to return your call

Other: _____

Signature of patient / legal representative: _____ Date: _____

