8559 SOUTH PULASKI ROAD
CHICAGO, IL 60652
TEL: 773-582-0035

10727 WEST 159TH STREET
ORLAND PARK, IL 60467
TEL: 708-364-1102

WWW.WINTERSETDENTAL.COM

Email ______________________________

Patient Information (CONFIDENTIAL)

Soc. Sec. # ____________________
Cell Phone ____________________

Name ______________________________ Birthdate ____________________ Home Phone ____________________

Address ______________________________ City ____________________ State __________ Zip __________

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If Student, Name of School / College ____________________ City ____________________ State ________ ❑ Full Time ❑ Part Time

Patient's or Parent's Employer ______________________________ Work Phone ____________________

Business Address ______________________________ City ____________________ State __________ Zip __________

Spouse or Parent's Name ____________________ Employer ____________________ Work Phone ____________________

Whom May We Thank for Referring You? ______________________________

Person to Contact in Case of Emergency ______________________________ Phone ____________________

Responsible Party

Name of Person Responsible for this Account ______________________________ Relationship To Patient ____________________

Address ______________________________ Home Phone ____________________

Driver's License # ____________________ Birthdate ____________________ Financial Institution ____________________

Employer ______________________________ Work Phone ____________________ SSN# ____________________

Is this Person Currently a Patient in our Office? ❑ Yes ❑ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

❑ Cash ❑ Personal Check ❑ Credit Card ❑ VISA ❑ MasterCard ❑ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured ______________________________ Relationship To Patient ____________________

Birthdate ____________________ Social Security # ____________________ Date Employed ____________________

Name of Employer ______________________________ Union or Local # ____________________ Work Phone ____________________

Address of Employer ______________________________ City ____________________ State __________ Zip __________

Insurance Company ______________________________ Group # ____________________ Policy/ID # ____________________

Ins. Co. Address ______________________________ City ____________________ State __________ Zip __________

How Much is your Deductible? __________ How Much Have You Used? ____________________ Max. Annual Benefit ____________________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ Yes ❑ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ______________________________ Relationship To Patient ____________________

Birthdate ____________________ Social Security # ____________________ Date Employed ____________________

Name of Employer ______________________________ Union or Local # ____________________ Work Phone ____________________

Address of Employer ______________________________ City ____________________ State __________ Zip __________

Insurance Company ______________________________ Group # ____________________ Policy/ID # ____________________

Ins. Co. Address ______________________________ City ____________________ State __________ Zip __________

How Much is your Deductible? __________ How Much Have You Used? ____________________ Max. Annual Benefit ____________________

Over Please

Patient Medical History

Physician____________________ Office Phone ____________________ Date of Last Exam____________________

	Yes	No
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑
If yes, please explain ____________________		
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑
If yes, what medication(s) are you taking? ____________________		
4. Have you ever taken Phen-Fen/Redux?	❑	❑
5. Do you use tobacco?	❑	❑
6. Do you use controlled substances?	❑	❑
7. Are you wearing contact lenses?	❑	❑

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	❑	❑	Heart Disease	❑	❑	Chest Pains	❑	❑
Heart Attack	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded	❑	❑
Rheumatic Fever	❑	❑	Heart Murmur	❑	❑	Stroke	❑	❑
Swollen Ankles	❑	❑	Angina	❑	❑	Hay Fever / Allergies	❑	❑
Fainting/Seizures	❑	❑	Frequently Tired	❑	❑	Tuberculosis	❑	❑
Asthma	❑	❑	Anemia	❑	❑	Radiation Therapy	❑	❑
Low Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma	❑	❑
Epilepsy / Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss	❑	❑
Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease	❑	❑
Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Heart Trouble	❑	❑
Kidney Disease	❑	❑	Hepatitis / Jaundice	❑	❑	Respiratory Problems	❑	❑
AIDS or HIV Infection	❑	❑	Sexually Transmitted Disease	❑	❑	Mitral Valve Prolapse	❑	❑
Thyroid Problems	❑	❑	Stomach Troubles / Ulcers	❑	❑	Other __________	❑	❑

9. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. novacaine)	❑	❑
Penicillin or other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (e.g. nickel, mercury, etc.)	❑	❑
Latex Rubber	❑	❑
Other (please list) ____________________	❑	❑

10. Women Only:

	Yes	No
a.) Are you pregnant or think you may be pregnant?	❑	❑
b.) Are you nursing?	❑	❑
c.) Are you taking oral contraceptives?	❑	❑

Patient Dental History

Name of Previous Dentist and Location____________________ Date of Last Exam____________________

	Yes	No
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Do you feel pain in any of your teeth?	❑	❑
5. Do you have sores or lumps in or near your mouth?	❑	❑
6. Do you have any head, neck, or jaw injuries?	❑	❑
7. Have you ever experienced any of the following problems in your jaw:		
Clicking?	❑	❑
Pain (joint, ear, side of face)?	❑	❑
Difficulty opening or closing?	❑	❑
Difficulty in chewing?	❑	❑
8. Do you have frequent headaches?	❑	❑
9. Do you clench or grind your teeth?	❑	❑
10. Do you bite your lips or cheeks frequently?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you ever had any prolonged bleeding following extractions?	❑	❑
13. Have you had any orthodontic treatments?	❑	❑
14. Do you wear dentures or partials If yes, date of placement?	❑	❑
15. Have you ever received oral hygiene instruction regarding the care of your teeth and gums?	❑	❑
16. 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 assessed. 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 my treatment or examination rendered to me or my child during the period of such Dental care's third party payers and/ or health practitioners'/ I authorize and request that my dental 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.

X____

Signature of patient (or parent if minor)

Doctor's Comments____

____

____________________ Signature____________________ Date ____________________