North Dental Professionals - Skokie
4711 Golf Rd. #412
Skokie, IL 60076
Ph # : 847-679-0555

Patient Personal Information

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				Emergency Contact	Emergency Phone #
Email				Student	SSN
Health Care Guardian Name				School Name	
Health Care Guardian Phone #				Referral Type	

Person responsible/guarantor for paying bills

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				SSN	
Email					

Do you have Primary Dental Insurance? __ Yes __ No				Do you have Secondary Dental Insurance? __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

Allergic To

- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Acrylic
- ☐ Y ☐ N Metal
- ☐ Y ☐ N Latex
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Other Antibiotics
- ☐ Y ☐ N Other Narcotics
- ☐ Y ☐ N Sedatives
- ☐ Y ☐ N Other allergies

Check all that apply

- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alzheimer's Disease
- ☐ Y ☐ N Artificial Heart Valve
- ☐ Y ☐ N Artificial Joint
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Blood Disease/Abnormal Bleedin
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Breathing Problems
- ☐ Y ☐ N Bruise Easily
- ☐ Y ☐ N Cancer/Radiation Treatment
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Chest Pains
- ☐ Y ☐ N Cold Sores/Fever Blisters
- ☐ Y ☐ N Congenital/Inborn Heart Defect
- ☐ Y ☐ N Convulsions
- ☐ Y ☐ N Cortisone Medicine - Last 2 yr
- ☐ Y ☐ N Excessive Thirst
- ☐ Y ☐ N Fainting Spells/Dizziness
- ☐ Y ☐ N Frequent Cough
- ☐ Y ☐ N Frequent Diarrhea
- ☐ Y ☐ N Frequent Headaches/Migraines
- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Heart Attack/Failure
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Heart Pacemaker/Defibrillator
- ☐ Y ☐ N Heart Trouble/Disease
- ☐ Y ☐ N Hemophilia
- ☐ Y ☐ N Hepatitis A or C
- ☐ Y ☐ N Hepatitis B
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Hives or Rash
- ☐ Y ☐ N Hypoglycemia
- ☐ Y ☐ N Osteoporosis
- ☐ Y ☐ N Pain in Jaw Joints
- ☐ Y ☐ N Parathyroid Disease
- ☐ Y ☐ N Psychiatric/Mental Healh Issue
- ☐ Y ☐ N Renal Dialysis
- ☐ Y ☐ N Rheumatic Fever/Damaged Heart
- ☐ Y ☐ N Rheumatism
- ☐ Y ☐ N Scarlet Fever
- ☐ Y ☐ N Shingles
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sickle Cell Disease
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Sleep Apnea
- ☐ Y ☐ N Stomach/Ulcers/Reflux/Acidity
- ☐ Y ☐ N Stroke

☐ Y ☐ N Anaphylaxis
☐ Y ☐ N Anemia
☐ Y ☐ N Angina
☐ Y ☐ N Anxiety Disorder/Panic Attacks
☐ Y ☐ N Arthritis/Gout
☐ Y ☐ N Crohn's Disease or Colitis
☐ Y ☐ N Depression
☐ Y ☐ N Diabetes
☐ Y ☐ N Diabetes - Insulin Treated
☐ Y ☐ N Drug Addiction
☐ Y ☐ N Emphysema/Bronchitis/COPD
☐ Y ☐ N Epilepsy or Seizures
☐ Y ☐ N Irregular Heartbeat
☐ Y ☐ N Kidney Disease/Failure
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Lung Disease
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Swelling of Limbs
☐ Y ☐ N Swollen Glands - Persistent
☐ Y ☐ N Thyroid Disease
☐ Y ☐ N Venereal Disease
☐ Y ☐ N Yellow Jaundice

Other

☐ Y ☐ N See Scanned Documents: Pt Note

Additional Comments

Dental Questionnaire

Dental History

Reason for today's visit: _____

Date of Last Dental Visit: _____

Date of Last Dental Cleaning: _____

Date of Last Full mouth X-Rays: _____

Concerns about today's visit: _____

Have you ever been told to take a pre-medication prior to dental treatment? _____

Concerns About Your Teeth

Do you experience tooth sensitivity? _____

Do your gums bleed or hurt? _____

Are you a mouth breather? _____

Do you snore or have a sleep disorder? _____

Do you experience soreness, popping or clicking of your jaw? _____

Previous Dental Treatment

Orthodontics? _____

Oral Surgery? _____

Periodontal treatment? _____

Bite plate or mouth guard? _____

Serious injury to mouth or head? _____

Tell Us About Your Smile

Would you like your teeth to be whiter? _____

Would you like to change anything about the appearance of your teeth? _____

If so, what would you like to change? _____

Medical Questionnaire

Are you under a physician's care now? _____

If Yes, please explain: _____

Date of last physical examination: _____

Have you ever been hospitalized or had a major operation? _____

If yes, please explain: _____

Have you had a serious illness in the last five years? _____

If yes, please explain: _____

Have you ever had a serious head or neck injury? _____

If yes, please explain: _____

Please list ALL PRESCRIPTION/NON-PRESCRIPTION medications you take, including DOSE & TIME OF DAY: _____

Do you take, or have you taken Phen-Fen or Redux? _____

If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? _____

If yes, please explain: _____

Do you smoke or use smokeless tobacco? _____

Are you a former tobacco user? _____

How many years have/did you use tobacco? _____

How much tobacco do/did you use per day? _____

Do you use/drink alcoholic beverages? _____

What type? _____

How many times per week do you use alcoholic beverages? _____

Do you use any illicit street drugs? _____

What type? _____

Do you wear contact lenses? _____

Do you have pain/sounds in your Temporomandibular joints? _____

Other Allergies

List other allergies _____

Women

Are you: pregnant/trying to get pregnant? _____

Taking oral contraceptives? _____

Nursing? _____

Other Medical Comments

Have you had any serious illness not listed above? _____

Comments _____

Oral Surgery Patients Only

Weight _____

Height	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature	**Date**
Dentist Signature	**Date**