

Fairview Dental Care
6317 Fairview Ave., Westmont, IL 60559
630-852-5353 Fax 630-968-0958

Patient's Name: _____ M F Date _____

I prefer to be called _____ Birthday _____ Age _____

Are any family members residing with you currently patients at Fairview Dental Care? ___ No ___ Yes

Home Address _____

Single ___ Married ___ Divorced ___ Widowed ___ SS# _____

Home Phone _____ Work Phone _____ Cell _____

Insurance Company _____ Name of Subscriber _____

Subscriber SS# _____ Subscriber Birthdate _____ Employer _____

Email Address _____ Referred By: _____

Emergency Contact _____ Phone _____

Family Physician _____ Phone _____

Are you under physicians care now? Yes No If yes, please explain _____

When was your last physical exam? _____ Do you use Tobacco? _____

Have you been hospitalized or had a major operation in the last 5 years? Yes No

If yes, please explain _____

Are you taking any prescription or over-the-counter drugs? Y/N Please list: _____

Are you allergic to any of the following: Aspirin ___ Penicillin ___ Codeine ___ Latex ___

Dental Anesthetics ___ Erythromycin ___ Sulfa ___ Metals ___ Other _____

Women only: Pregnant/Trying to get pregnant? Yes No Nursing? Yes No

Taking Oral Contraceptives: Yes No If yes, name of Birth control _____

Are you taking or have you ever taken any of the following medications for any type of cancer, osteoporosis or bone loss due to aging, Paget's disease, or multiple myeloma? Yes No

Bisphosphonates: (Orally or IV Administered)

Alendronate (Fosamax) ____ Ibandronate (Boniva) ____ Olpadronate ____

Etidronate (Didronel) ____ Risedronate (Actonel) ____ Tiludronate (Skelid) ____

Have you ever taken Phen Phen or Redux? Yes No

Have you ever been told you need to Premedicate prior to a dental procedure? Yes No

Do you have or have you had any of the following diseases/problems? Please circle Y/N

Y/N	High Blood Pressure	Y/N	Artificial Prosthetic Heart Valve
Y/N	Angina/Chest Pain	Y/N	Congenital heart disease
Y/N	Asthma/Lung/Respiratory condition	Y/N	Infective Endocarditis
Y/N	Diabetes	Y/N	Heart murmur/Mitral Valve Prolapse
Y/N	Emotional/Mental Health disorder	Y/N	Rheumatic heart disease
Y/N	Epilepsy/Seizure/Convulsions	Y/N	Congestive Heart Failure
Y/N	Hepatitis/Liver Disease	Y/N	Pacemaker
Y/N	HIV Positive/AIDS	Y/N	Cardiovascular Disease
Y/N	Sleep Apnea/Disorder	Y/N	Cancer/Chemo/Radiation Therapy
Y/N	Kidney/Renal Disease	Y/N	Immune Suppressions or Deficiency
Y/N	Stomach Ulcers	Y/N	Heart Attack Date: _____
Y/N	Thyroid Disease	Y/N	Heart Surgery Date: _____
Y/N	Tuberculosis	Y/N	Stroke Date: _____
Y/N	Artificial/Prosthetic Joint Replacement	Y/N	Cancer Date: _____

Have you ever had any serious illness not listed above? Y/N If yes, please explain _____

Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck?

Abnormal Bleeding Y/N Do you take blood thinners? Y/N Coumadin (Warfarin) ____ Plavix (Clopidogrel) ____
Fragmin (Dalteparin) ____ Orgaran (Danaparoid) ____ Lovenox (Enoxaparin Sodium) ____ Arixtra (Fondaparinux Sodium) ____
Heparin (Porcine) ____ Aspirin ____

DENTAL HISTORY

Name of Previous Dentist: _____ Date of Last Visit: _____

- | | | | |
|-----|------------------------------------|-----|--|
| Y/N | Are you currently in pain? | Y/N | Apprehensive about dental treatment? |
| Y/N | Do your gums ever bleed? | Y/N | Do you have a history of periodontal concerns? |
| Y/N | Do you have discomfort in jaw/TMJ | Y/N | Do you clench or grind your teeth? |
| Y/N | Have you had previous Ortho Trtmt? | Y/N | Are your teeth sensitive? |
| Y/N | Do you wear Dentures/Partials? | Y/N | Do you have dental implants? |
| Y/N | Do you suffer from dry mouth? | Y/N | Broken bones of face, neck, jaw or back? |

Do you like your smile? Y/N Rank you smile on a scale of 1 2 3 4 5 6 7 8 9 10
Color? Y/N 1- unhappy 10- Very Happy
Position/Orthodontics? Y/N If not 10, what can we do to make it a 10?
Shape of Teeth? Y/N _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

I will pay all applicable co-pays and outstanding patient balances as they become due. All co-pays and patient balances are due at each visit. Accounts with no activity for 60 days may be forwarded for further collection action. If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees. Any and all advance collection fees incurred by the practice will be included in my final bill.

I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE

Patient Signature _____ Date _____

Parent or Guardian of Patient: _____