NORTHBROOK DENTAL CARE, LLC.

JAY RODGERS, D.D.S
1135 Church St. Northbrook, IL 60062 (847) 205-9337
www.northbrookdentalcare.com

Date_____

PATIENT INFORMATION

Name- First:_____Last:_____
Birth Date: _____ Social Security: _____
☐ Single ☐ Married ☐ Divorced ☐ Separated
Address: _____ City: _____State: _____ Zip:_____
Home Phone: _____ Cell Phone: _____
Email: _____
How did you hear about our office? _____
Emergency Contact: _____ Phone #: _____

RESPONSIBLE PARTY

Name of Person Responsible for This Account: _____
Relationship to Patient: _____ Birth Date: _____
Home Phone: _____ Cell Phone: _____
Address: _____ City: _____ State:____ Zip:_____
Is this person currently a patient in our office? ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION

☐ No Dental Insurance

Insurance Company: _____ Phone Number: _____
Insurance ID#: _____ Group #: _____
Name of Insured: _____ Birth Date: _____
SSN: _____Relationship to Patient: _____

PATIENT DENTAL HISTORY

Name of previous Dentist: _____ Date of Last Exam: _____

1. Do your gums bleed while brushing or flossing? Yes No
2. Are your teeth sensitive to hot or cold? Yes No
3. Are your teeth sensitive to sweet/sour? Yes No
4. Do you have any tooth pain? Yes No
5. Any sores or lumps near/in your mouth? Yes No
6. Any head, neck or jaw injuries? Yes No
7. Do you have frequent headaches? Yes No
8. Do you grind or clench your teeth? Yes No
9. Do you bite your lips or cheeks? Yes No
10. Have you had Orthodontic treatment? Yes No
11. Do you wear partials/dentures? Yes No
    If yes, date of placement _____
12. Have you experienced any of the following in your jaw?
    - Clicking Yes No
    - Pain (joint, ear, side of face) Yes No
    - Difficulty opening/closing Yes No
    - Difficulty chewing Yes No

PATIENT MEDICAL HISTORY

Physician: _____ Date of Last Exam: _____

1. Do you have or have you had any of the following:

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ Thyroid Problem
- ☐ Fainting/Seizures
- ☐ Asthma
- ☐ Epilepsy/Convulsions
- ☐ Leukemia
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ AIDS/HIV
- ☐ Heart Disease
- ☐ Cardiac Pacemaker
- ☐ Heart Murmur
- ☐ Angina
- ☐ Emphysema
- ☐ Cancer
- ☐ Arthritis
- ☐ Joint Replacement
- ☐ Hepatitis/Jaundice
- ☐ Sexually Transmitted Disease
- ☐ Stomach Troubles/Ulcers
- ☐ Chest Pain
- ☐ Easily Winded
- ☐ Stroke
- ☐ Hay Fever
- ☐ Tuberculosis
- ☐ Radiation Therapy
- ☐ Glaucoma
- ☐ Recent Weight Loss
- ☐ Liver Disease
- ☐ Heart Trouble
- ☐ Respiratory Problem
- ☐ Mitral Valve Prolapse
- ☐ Other: _____

2. Are you under medical treatment now? Yes No

3. Have you been hospitalized for a surgery or serious illness within the last 5 years? Yes No

4. Are you currently taking any medications, prescription and non-prescription? Yes No

If yes, please list them: _____

_____

5. Have you ever taken Phen-Fen/Redux? Yes No

6. Do you use controlled substances? Yes No

7. Do you use/have you used the following?

- ☐ Tobacco
- ☐ Vape
- ☐ Cigars
- ☐ Cannabis

8. Do you/have you ever taken bisphosphates?

- Reclast Yes No
- Boniva Yes No
- Fosamax Yes No

9. Are you allergic or have had any reactions to:

- ☐ Latex Rubber
- ☐ Local Anesthetics
- ☐ Penicillin or other Antibiotics
- ☐ Sulfa Drugs
- ☐ Barbiturates
- ☐ Sedatives
- ☐ Iodine
- ☐ Aspirin
- ☐ Other: _____

10. Do you have, or have you had any disease/condition not listed? Yes/No If yes, explain: _____

_____

<u>WOMEN ONLY:</u>

Are you pregnant? Yes No

Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

OFFICE FINANCIAL POLICY

For patients with no dental insurance:

It is customary for us to receive full payment for services rendered at the time of your appointment. When extensive treatment is planned that require multiple appointments, it may be necessary to make arrangements before the treatment is scheduled.

For patients with dental benefit covering part of treatment cost:

Dental benefits are typically provided by an employer to help their employees pay for routine dental treatment. Most benefit plans are only designed to cover a portion of the cost. We ask for your co-payment at the time of service.

Last minute cancellations and missed appointments:

If you are unable to keep a scheduled appointment, please give a 48 hours advance notice to ensure that you will not be changed for the appointment. If less than a 24 hour notice is given, we reserve the right to charge a missed appointment fee.

-I have read and understand the office financial policy and fully intend to stand by the financial arrangements made with the office.

_____

(Signature)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices(by request). (Print Name)

_____

(Signature)

_____

(Date)