CHICAGO
DENTAL SOLUTIONS

NEW PATIENT REGISTRATION

First Name:_____ Last Name:_____

Preferred Name:_____ Birth Date:_____

Address:_____ Apt#_____ City:_____ State:_____ Zip:_____

Cell Phone:_____ ☐ Yes, send me Text Message alerts

Work Phone:_____ Ext#_____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Other:_____

E-mail Address:_____ ☐ Yes, send me alerts via Email

Emergency Contact:_____ Phone:_____

Previous Dentist and/or Dental Office:_____

How did you hear about us?

☐ I live/work in area ☐ Google ☐ Yelp ☐ Social Media

☐ I was Referred by:_____

☐ Other:_____

Insurance Information

☐ No Dental Insurance

☐ Primary Insurance (Policy Holder)

Name of Insurance Company: _____ State:_____

Policy Holder Name:_____ Birth Date#:____/____/_____

Member ID/ SS#:_____ Group#: _____

Name of Employer:_____

Relationship to Insurance holder: ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Other: _____

☐ Responsible Party (someone other than self is the Insurance Policy Holder)

Name of Insurance Company:_____ State:_____

Policy Holder Name:_____ Birth Date:____/____/_____

Member ID/ SS#:_____ Group#:_____

Name of Employer:_____

Relationship to Insurance holder: ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Other:_____

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MEDICAL HISTORY

Although dental professionals primarily treat the area around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐Yes ☐No If yes, please explain:_____

Have you ever been hospitalized/ had major surgery? ☐Yes ☐No If yes, please explain:_____

Have you ever had a serious head/ neck injury? ☐Yes ☐No If yes, please explain:_____

Are you taking any medications, pills or drugs? ☐Yes ☐No If yes, please explain:_____

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No _____

Have you ever taken Fosamax, Boniva, Actonel/ other medications containing bisphosphonates? ☐Yes ☐No _____

Are you on a special diet? ☐Yes ☐No

Do you use tobacco? ☐Yes ☐No

Do you use controlled substances? ☐Yes ☐No

Women are you : ☐Pregnant ☐Trying to get pregnant ☐Nursing ☐Taking oral contraceptives

Are you allergic to any of the following? ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex

☐Local Anesthesia ☐Sulfa Drugs ☐Other:_____

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

- ☐AIDS/HIV Positive
- ☐Alzheimer's Disease
- ☐Anaphylaxis
- ☐Anemia
- ☐Angina
- ☐Arthritis/Gout
- ☐Artificial Heart Valve
- ☐Artificial Joint
- ☐Asthma
- ☐Blood Disease
- ☐Blood Transfusion
- ☐Breathing Problem
- ☐Bruise Easily
- ☐Cancer
- ☐Chemotherapy
- ☐Chest Pains
- ☐Cold Sores/Fever Blisters
- ☐Congenital Heart Disorder
- ☐Convulsions
- ☐Cortisone Medicine
- ☐Diabetes
- ☐Drug Addiction
- ☐Easily Winded
- ☐Emphysema
- ☐Epilepsy/ Seizers
- ☐Excessive Bleeding
- ☐Excessive Thirst
- ☐Fainting/Dizzy Spells
- ☐Frequent Cough
- ☐Frequent Diarrhea
- ☐Frequent Headaches
- ☐Genital Herpes
- ☐Glaucoma
- ☐Hay Fever
- ☐Heart Attack/Failure
- ☐Heart Murmur
- ☐Heart Pacemaker
- ☐Heart Trouble/Disease
- ☐Hemophilia
- ☐Hepatitis A
- ☐Herpes
- ☐High Blood Pressure
- ☐High Cholesterol
- ☐Hives/Rash
- ☐Hypoglycemia
- ☐Hypoglycemia
- ☐Irregular Heartbeat
- ☐Kidney Problems
- ☐Leukemia
- ☐Liver Disease
- ☐Low Blood Pressure
- ☐Mitral Valve Prolapse
- ☐Osteoporosis
- ☐Pain in Jaw Joints
- ☐Parathyroid Disease
- ☐Psychiatric Care
- ☐Radiation Treatments
- ☐Recent Weight Loss
- ☐Renal Dialyses
- ☐Rheumatic Fever
- ☐Rheumatism
- ☐Scarlet Fever
- ☐Shingles
- ☐Sickle Cell Disease
- ☐Sinus Trouble
- ☐Spina Bifida
- ☐Stomach/Intestinal Disease
- ☐Stroke
- ☐Swelling of Limbs
- ☐Thyroid Disease
- ☐Tonsillitis
- ☐Tuberculosis
- ☐Tumors/Growths
- ☐Ulcers
- ☐Venereal Disease
- ☐Yellow Jaundice

Have you had any serious illness not listed above? ☐Yes ☐No

If yes, please explain:_____

Comments:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or professionals) health. It is my responsibility to inform the dental official of any changes in medical status.

Signature of Patient, Parent or Guardian:_____ **Date**:_____

LINCOLN DENTAL CARE
3138 N Lincoln Ave Chicago, IL 60657

MIDWAY SQUARE DENTAL CENTER
5109B S Pulaski Rd.
Chicago, IL 60632

CHICAGO DENTAL DESIGN
845 N Michigan Ave Suite 945W
Chicago, IL 60611