# Welcome

*Thank you for selecting our dental healthcare office! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.*

## Patient Information (Confidential)

Name ________________________________________ Birthday ____________ Home Phone _______________________
Mobile / Cell Phone #_______________________ Pager # _________________ Work Phone _______________________
Social Security # ______________________________ Driver's License #. Or ID _________________________________
Address ________________________________________ City ______________________ State _______ Zip __________
Check Appropriate Box: ? Minor ? Single ? Married ? Divorced ? Widowed ? Separated
If Student Name of School / College ______________________ City ________________ State _____ ? Full ? Part
Patient's Employer _____________________________________ Business Address ______________________________
City ____________________________________ State ____________________ Zip ______________________________
Spouse Name ____________________ Employer ______________________ Work Phone _______________________
Whom May We Thank for Referring You? ______________________________________ Phone ___________________
Person to Contact in Case of Emergency _________________________________________________________________

## Responsible Party

Name of Person Responsible for this Account ___________________________ Relationship to you ________________
Address _____________________________________________________ Home Phone ____________________________
Driver's License # ____________________________ Birthday __________ SSN # ______________________________
Employer ___________________________________________________ Work Phone ______________________________
Is This Person a Patient in our Office? ? Yes ? No

## Insurance Information

Name of Insured __________________________________________________ Relationship to you _________________
Birthday _______________________ Social Security # __________________ Date of Employment _______________
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 ___________ Phone Number ______________________ Effective Date_______________________

*DO YOU HAVE ANY ADDITIONAL INSURANCE? ? YES ? NO IF YES, COMPLETE THE FOLLOWING*

Name of Insured __________________________________________________ Relationship to you__________________
Birthday ______________________________ Social Security # ______________________________________________
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 ___________ Phone Number ______________________ Effective Date ______________________

***Dr. John Giannopoulos | 9520 Franklin Ave. | Franklin Park, IL 60131***
***847-455-1237***

*OVER PLEASE*
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# Patient Medical History

| | 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 are you taking ______________________ | | |
| 4. Do you use tobacco? | | |
| 5. Do you use controlled substances? | | |
| 6. Are you wearing contact lenses? | | |

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

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

8. Women Only:

| | Yes | No |
|---|---|---|
| a) Are you pregnant, or might be? | | |
| b) Are you nursing? | | |
| c) Are you taking oral contraceptives? | | |

| | Yes | No |
|---|---|---|
| High Blood Pressure | | |
| Heart Attack | | |
| Rheumatic Fever | | |
| Swollen Ankles | | |
| Fainting/ Seizures | | |
| Asthma | | |
| Low Blood Pressure | | |
| Epilepsy/ Convulsions | | |
| Leukemia | | |
| Diabetes | | |
| Kidney Disorders | | |
| AIDS or HIV Infection | | |
| Thyroid Problems | | |

| | Yes | No |
|---|---|---|
| Heart Disease | | |
| Pacemaker | | |
| Heart Murmur | | |
| Angina | | |
| Frequently Tired | | |
| Anemia | | |
| Emphysema | | |
| Cancer | | |
| Arthritis | | |
| Joint Replacement or Implants | | |
| Hepatitis / Jaundice | | |
| Sexually Transmitted | | |
| Stomach Troubles/ Ulcers | | |

| | Yes | No |
|---|---|---|
| Chest Pains | | |
| Easily Winded | | |
| Stroke | | |
| Hay Fever/ Allergy | | |
| Tuberculosis | | |
| Radiation Therapy | | |
| Glaucoma | | |
| Recent Weight Loss | | |
| Liver Disease | | |
| Heart Trouble | | |
| Respiratory Problems | | |
| Mitral Valve Prolapse | | |
| Other | | |

# Patient Dental History

Date of Last Exam ________________

| | Yes | No |
|---|---|---|
| 1. Do your gums bleed while brushing/flossing? | | |
| 2. Sensitivity to hot or cold liquids? | | |
| 3. Sensitivity to sweet or sour liduids/foods | | |
| 4. Pain in any of your teeth? | | |
| 5. Sores or lumps in or near your mouth? | | |
| 6. Have you had any head, neck or jaw injuries? | | |
| 7. Have you ever had any of the following? | | |
| Clicking | | |
| Pain (Joint, ear, side of face)? | | |
| Difficulty in opening or closing? | | |
| Difficulty in chewing | | |

| | Yes | No |
|---|---|---|
| 8. Do you have frequent headaches? | | |
| 9. Do you clinch or grind your teeth? | | |
| 10. Do you bite your lip or cheek frequently? | | |
| 11. Have you ever had any diffcult extractions in the past? | | |
| 12. Have your ever had prolonged bleeding following an extraction? | | |
| 13. Have you had any orthodontic treatment? | | |
| 14. Do you wear partials or dentures? If yes date of placement ____________________ | | |
| 15. Have you ever received oral hygiene instruction regarding the care of your teeth and gums | | |

# Authorization and Release

I certify that I have read and understand the above the information to the best of my knowledge. The above questions have been accurately answered. 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 any treatment or examination render to me or my child during the period of such Dental care to a third party payers and/or health practitioners. I authorize and release my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental carrier may pay less than the actual for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

Please be aware that after any no-show or cancellation without 24 notice, you will be liable for $25.00 fee per 1/2 hour. This fee will not be covered by or payable by insurance companies. It will be your responsibility to pay this fee prior to your next visit.

**A 1.5% will be added to any account with a balance over 30 days. On uncollectable balances the patient will be responsible for all legal and court fees.**

X________________________________________________________ Date _________________

Signature of patient ( or parent if minor)