Instructions

Please fill out the form as completely as possible. When you're done, you have two choices. Click the button below to either:

1) Click the "Submit by Email" button and send this document to our office; or
2) Print the form and bring it with you to your appointment

Smiling Patient Dental Care
Bianca Malin,DDS Patrick Magner,DMD
322 N. Wolf Rd Mt. Prospect, IL 60056
847.824.5151 office 847.824.8981 fax
www.smilingpatient.com

Welcome

Print Form

Reset Form

Patient Information

SSN _____ Current Date _____

First Name _____ Initial ____ Last Name _____

Address _____

City _____ State ____ Zip Code _____

Sex _____ Marital Status _____ Birthday _____

Occupation _____

Employer _____

Contact Information

Email _____

Home Phone _____

Work Phone _____

Cell Phone _____

IN CASE OF EMERGENCY, CONTACT:
(Specify someone who does not live in your household)

Name _____

Home Phone _____

Relationship _____

Questionnaire

Whom may we thank for referring you?

What is important to you when choosing your new dentist?

Are you satisfied with your tooth appearance?	Yes	No
Are you satisfied with your tooth color?	Yes	No
Do you feel your teeth are crowded?	Yes	No
Do you feel your teeth are poorly aligned?	Yes	No
Do you feel your teeth are protruding?	Yes	No
Do you suffer from dental decay in your front teeth?	Yes	No
Do you have non-esthetic front teeth restorations?	Yes	No
Do you have fractures in your front teeth?	Yes	No
Are you hiding your teeth while smiling?	Yes	No

Dental Insurance

Relationship to Patient? _____

Insurance Company _____

Subscriber's Name _____

Subscriber's Birthday _____ SSN _____

Group # _____

Medications

List any medications you are currently taking and the correlating diagnosis:

☐ None

Allergies

☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Skin reaction to jewelry
☐ Any known metal allergies
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other (Specify)

☐ None

Dental History

Reason for Today's Visit

Former Dentist

City/State

Date/Last Visit

Date/Last Dental X-Rays

Please select "Yes" or "No" to indicate if you have had any of the following:

Bad breath ◯ Yes ◯ No
Bleeding Gums ◯ Yes ◯ No
Blisters on Lips or Mouth ◯ Yes ◯ No
Burning sensation on tongue ◯ Yes ◯ No
Chew on one side of mouth ◯ Yes ◯ No
Smoking or Tobacco use ◯ Yes ◯ No
Clicking or popping jaw ◯ Yes ◯ No
Dry mouth ◯ Yes ◯ No
Fingernail biting ◯ Yes ◯ No
Food collection between teeth ◯ Yes ◯ No
Grinding Teeth ◯ Yes ◯ No
Loose teeth or broken fillings ◯ Yes ◯ No
Mouth breathing ◯ Yes ◯ No
Mouth pain, brushing ◯ Yes ◯ No
Orthodontic treatment ◯ Yes ◯ No
Pain around ear ◯ Yes ◯ No
Periodontal treatment ◯ Yes ◯ No
Sensitivity to cold ◯ Yes ◯ No
Sensitivity to heat ◯ Yes ◯ No
Sensitivity to sweets ◯ Yes ◯ No
Sensitivity when biting ◯ Yes ◯ No
Sores or growths in your mouth ◯ Yes ◯ No

How often do you brush?

How often do you floss?

Health History

Physician's Name _____ City/State _____ Date/Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (Brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine?) ◯ Yes ◯ No

Please select "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ◯ Yes ◯ No
Anemia ◯ Yes ◯ No
Arthritis, Rheumatism ◯ Yes ◯ No
Artificial Heart Valves ◯ Yes ◯ No
Artificial Joints ◯ Yes ◯ No
Asthma ◯ Yes ◯ No
Back Problems ◯ Yes ◯ No
Bleeding abnormally, with extractions or surgery ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No
Cancer ◯ Yes ◯ No
Chemical Dependency ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No
Circulatory Problems ◯ Yes ◯ No
Congenital Heart Lesions ◯ Yes ◯ No
Cortisone Treatments ◯ Yes ◯ No
Cough, persistent or bloody ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No
Do you wear contact lenses? ◯ Yes ◯ No
Emphysema ◯ Yes ◯ No
Epilepsy ◯ Yes ◯ No
Fainting or dizziness ◯ Yes ◯ No
Glaucoma ◯ Yes ◯ No
Headaches ◯ Yes ◯ No
Heart Murmur ◯ Yes ◯ No
Heart Problems ◯ Yes ◯ No
Hepatitis Type ___ ◯ Yes ◯ No
Herpes ◯ Yes ◯ No
High blood pressure ◯ Yes ◯ No
Jaundice ◯ Yes ◯ No
Jaw Pain ◯ Yes ◯ No
Kidney Disease ◯ Yes ◯ No
Liver Disease ◯ Yes ◯ No
Low Blood Pressure ◯ Yes ◯ No
Mitral Valve Prolapse ◯ Yes ◯ No
Nervous Problems ◯ Yes ◯ No
Pacemaker ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No
Radiation Treatment ◯ Yes ◯ No
Respiratory Disease ◯ Yes ◯ No
Rheumatic Fever ◯ Yes ◯ No
Scarlet Fever ◯ Yes ◯ No
Shortness of breath ◯ Yes ◯ No
Sinus trouble ◯ Yes ◯ No
Skin rash ◯ Yes ◯ No
Special diet ◯ Yes ◯ No
Stroke ◯ Yes ◯ No
Swollen feet or ankles ◯ Yes ◯ No
Swollen neck glands ◯ Yes ◯ No
Thyroid problems ◯ Yes ◯ No
Tonsillitis ◯ Yes ◯ No
Tuberculosis ◯ Yes ◯ No
Tumor or growth on head or neck ◯ Yes ◯ No
Ulcer ◯ Yes ◯ No
Weight loss, unexplained ◯ Yes ◯ No

Women Only:
Are you pregnant? ◯ Yes ◯ No Due date _____
Are you nursing? ◯ Yes ◯ No
Taking birth control pills? ◯ Yes ◯ No

Please identify special needs or anything you feel will help