Robles
Family Dental

A Multi- Specialty Office for All Ages
3253 S. Harlem Ave, suite IC Berwyn, IL 60402

Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name (Last, First MI.) _____ Soc.Sec.# _____
Address_____
City _____ State _____ Zip _____ Home #_____
Cell Phone_____ Email_____ Sex M/F
Age _____ Birthdate_____ Single____ Married ____ Widowed ____ Other _____
Patient Employed By _____ Occupation _____
Business Address_____Business Phone #_____
Business Email_____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home #_____
Cell phone_____ Work phone _____

Primary Dental Insurance

Person Responsible for Account _____
Relation to patient _____Birthdate _____ Soc. Sec.# _____
Address (if different from patient) _____
City _____ State _____ Zip _____ Home # _____
Cell phone_____ Email _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business phone _____
Insurance Co.Ins. # _____Group #_____ Subscriber # _____
Names of dependents under this plan _____

Additional Dental Insurance

Is patient covered by additional dental insurance? Y/N Subscriber Name _____
Relation to patient _____ Birthdate _____ Soc.Sec.# _____
Subscriber Employed by _____ Business Ph.# _____
Insurance CompanyPhone # _____ Group # _____
Subscriber # _____

Patient Name: _____

Dental History

What would you like us to do today? _____
Are you in dental discomfort today? _____
Former Dentist _____ Phone # _____
Date of last dental care Date of last x-rays Circle Y/N if you have had any of the following:

Y/N Bad Breath
Y/N Food collection between teeth
Y/N Periodontal treatment
Y/N Sensitivity to sweets
Y/N Bleeding gums
Y/N Grinding or clenching teeth
Y/N Sensitivity to cold /Hot
Y/N Sensitivity when biting
Y/N Clicking or popping jaw
Y/N Loose teeth or broken fillings
Y/N Sores or growth in mouth

How often do you brush? _____ Floss? _____
How do you feel about the appearance of your teeth?
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y/N If yes, explain _____
Other information about your dental health or previous treatment

Medical History

Physician's Name _____ Phone # _____
Date of last visit _____
Have you ever had any serious illnesses or operations? Y/N If yes, describe
Are you currently under physician care? Y/N If yes, describe
Have you ever been required to take antibiotics before a dental appointment? Y/N
Have you ever had a blood transfusion? Y/N If yes, give approx. dates Women:
Are you pregnant? Y/N Nursing? Y/N Taking birth control pills? Y/N
Circle Y/N whether you have had any of the following:

Y/N AIDS/HIV Positive	Y/N Headaches	Y/N Radiation Treatment
Y/N Anaphylaxis	Y/N Heart Problems	Y/N Respiratory Disease
Y/N Anemia	Y/N Heart Murmur	Y/N Rheumatic/Scarlet
Y/N Arthritis, Rheumatism	Y/N Hemophilia/Abnormal Bleeding	Y/N Shortness of Breath
Y/N Artificial Heart Valve	Y/N Herpes	Y/N Spina Bifida
Y/N Artificial Joints	Y/N Hepatitis	Y/N Stroke
Y/N Asthma	Y/N High Blood Pressure	Y/N Surgical Implant
Y/N Back Problems	Y/N Jaw Pain	Y/N Thyroid Hypo/Hyper
Y/N Blood Disease	Y/N Kidney Disease or Malfunction	Y/N Seizure
Y/N Cancer	Y/N Rapid Weight Gain/Loss	Y/N Tuberculosis
Y/N Liver Disease	Y/N Tobacco Habit	Y/N Ulcer / Colitis
Y/N Chemotherapy	Y/N Material Allergies (Latex, Metal)	Y/N Venereal Disease
Y/N Circulatory Problems	Y/N Mitral Valve Prolapse	Y/N Glaucoma
Y/N Cortisone Treatments	Y/N Nervous Problems	Y/N Psychiatric Care
Y/N Diabetes	Y/N Pacemaker	Y/N Epilepsy

Is patient currently taking any medications? Y/N If yes, please list all:

_____

Does patient have any drug allergies? Y/N If yes, please list all:

_____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, will inform the dentist.

I authorize the insurance company indicated on the first page of these forms to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date_____