SMILE CHICAGO
Sheldon Seidman, DDS

Benefits of a healthy and beautiful smile are immeasurable. Our Goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

About You:

Today's date: _____*Reason for today's visit:* _____

Items marked with asterisk (*) must be completed.

Full Name*_____Gender:_____ Date of Birth:* _____

I like to be called: _____

Who may we thank for referring you to our office:* _____

SSN#* (required to submit a claim to your benefits company)_____

Home adrs:*___ _____City_____State: _____ Zip:_
_____

Home/Cell #* _____Work/Office: _____ Email address:*_
_____

If patient is a minor, the parent who brought child will be considered responsible party:

Parent/ Guardian name:* _____ Cell#:* _____

In case of emergency please provide the name and telephone number of who to contact:*

_____

RESPONSIBLE PARTY INFORMATION:

Name of responsible party: *_____

Relationship to patient: *_____

Home phone or cell #: *_____ Email Address:*_____

DENTAL INSURANCE INFORMATION:

Insured's name: *_____Insured's DOB: *_____Insured's SSN#*_____

Plan Name: _____ Plan Group # _____ Plan tel # _____

MEDICAL HISTORY:

Please fill out this section to the best of your knowledge. It is important for us to be aware of any health issues that may affect the treatment you receive from our office. This information is kept strictly confidential.

Physician Name: _____ Physician Tel #: _____

Physician address: _____ Date of last visit: _____

MEDICAL HISTORY:

Have you ever had or been treated for any of the following diseases or medical problems? Please circle yes or no.

Y/N Abnormal bleeding

Y/N Anemia

Y/N Arthritis

Y/N Asthma or Hay Fever

Y/N Bone Disorders

Y/N Congenital Heart Defect/ Heart Murmur

Y/N Heart Problems

Y/N Rheumatic Fever

Y/N Dizziness/ Fainting Spells

Y/N Epilepsy

Y/N Sexually transmitted disease

Y/N HIV / AIDS

Y/N High/Low Blood Pressure

Y/N Kidney Problems

Y/N Tuberculosis

Y/N Pneumonia

Y/N Nervous Disorders/ Psychiatric

Y/N Cancer/ Tumor/ Radiation/Chemo

Y/N Gastrointestinal Disorders/ IBS

Y/N Hepatitis/ Liver Disease

Please list all prescribed and non-prescribed medications you are presently taking to include vitamins, herbal supplements and their dosages:

_____

_____

_____

Have you had any serious medical problems or been hospitalized within the past 5 years (if so, please explain)_____

_____

_____

Are there any medical conditions not listed that you feel we should be made aware of (is so please explain:

_____
_____
____

DENTAL HISTORY:

Are you allergic to any of the following:

Y/N Penicillin

Y/N Latex

Y/N Aspirin

Y/N Erythromycin

Y/N Codeine

Y/N Dental anesthetic

Are you allergic to any other medications? If yes please explain:

_____
_____
_____

Previous Dentist Name: _____ Date of last visit:____
_____

If you could change anything about the appearance of your smile, what would it be?

_____
____

If you could easily and safely whiten your teeth, would you be interested? **Y/N**

Are you currently in pain or discomfort with your teeth and/or your gums? **Y/N**

Is any part of your mouth sensitive to temperature or sweets? **Y/N**

How often do you brush your teeth?
_____

How often do you floss your teeth?
_____

Do your gums bleed when you brush or floss your teeth? **Y/N**

Have you experienced an unfavorable reaction to dental anesthetic, such as an allergic reaction?

If so please explain.

_____

Have you lost or chipped any teeth? **Y/N**

If so please explain**:**

_____

Have there been any injuries to your face, mouth or teeth? **Y/N** if so please explain,

_____

____

HEADACHE SECTION:

Do you get or have you had a history of headaches? **Y/N**
(migranes, tension, sinus headaches, TMJ, etc.)

At what age can you remember the headaches starting?

_____

Have you had any jaw pain and/or are you aware of your jaws clicking and popping? If so when?

_____

__

Are you aware or have you been made aware of clenching or grinding your teeth during the day and/or at night? **Y/N** if so please explain:

_____

Have you ever experienced chronic ringing in your ears or do your ears feel full (stuffy)?

Comments:

_____

_____

__

By signing this document I am acknowledging the above information to be correct and true. I understand that it will be held within the privacy guidelines as set forth by HIPAA and be used to improve communication between the Doctor and myself. I also give permission for the doctor and his team to use any photos that may be needed for lab communication, educational and promotional purposes including the website.

X_____Date:

_____

Patient Signature