



PATIENT INFORMATION

DATE

Male Female Single Married Divorced Widowed

Name: _____
First Middle Last What name do you prefer to be called?

Address: _____
Street Apt. # City State Zip Code

Home phone: () _____ Cell phone: () _____ Birthday: _____

Social Sec.# _____ Full Time Student? If yes, what school do you attend? _____

Whom may we thank for referring you to our office? _____

In case of emergency, Who should be notified? _____ Telephone# () _____

INSURANCE INFORMATION

Insured's Name _____ Birthdate: _____ Social Sec.# _____

Name of employer: _____ Occupation: _____

Business Address: _____ Business # () _____ Are calls allowed?

Name of Dental Ins. Company: _____ Group # _____

Who is responsible for any balance not paid by the ins. company? _____ Relationship to patient: _____

DENTAL HISTORY

When was your last dental check up? _____ How many times a day do you brush your teeth? _____

Do you floss? _____ How often? _____ Do your gums bleed? _____

Are your teeth sensitive to hot or cold? YES NO Do you smoke? YES NO Do you snore? YES NO

Do you grind or clench your teeth? YES NO Does your jaw pop or click? YES NO

Would you like your teeth whiter? YES NO

Have dental procedures ever been recommended to you that you did not have done? _____

Are you having any pain or discomfort at this time? YES NO Where? _____

What is your main dental concern today? _____

On a scale of 1 to 10 (1 being not important at all and 10 being very important) what priority would you give your teeth? _____

PLEASE TURN THE PAGE OVER AND FILL OUT THE OTHER SIDE

OLYMPIA FIELDS DENTAL ASSOCIATES

2555 Lincoln Highway, Suite 107 | Olympia Fields, IL 60461 | Phone: **708-481-1818** | Fax: 708-481-1233

www.ofsmiles.com



MEDICAL HISTORY

Physician's Name: _____ Phone () _____

Physician's Address: _____ City, State & Zip Code: _____

Has there been any change in your general health within the past year? _____

Are you now under the care of a physician? YES NO If yes, what is the condition being treated? _____

Do you know your blood pressure? YES NO If yes, what is it? _____

When was your last physical examination? _____

Are you taking any medications at this time? YES NO If yes, what medications? _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____

Have you ever responded adversely to medical or dental treatment? _____

Have you ever had any of the following? (please circle yes or no)

- | | | |
|--|---------------------------------|-------------------------------|
| AIDS/HIV? YES NO | Chemotherapy? YES NO | Mitral Valve Prolapse? YES NO |
| Allergies to Anesthetics? YES NO | Congenital Heart Lesion? YES NO | Respiratory Disease? YES NO |
| Arthritis? YES NO | Diabetes? YES NO | Rheumatic Fever? YES NO |
| Artificial Heart Valve or Joints? YES NO | Heart Murmur? YES NO | Sinus Trouble? YES NO |
| Asthma? YES NO | Heart Surgery? YES NO | Tuberculosis? YES NO |
| Blood Disease? YES NO | Hepatitis? YES NO | Venereal Disease? YES NO |
| Cancer? YES NO | High Blood Pressure? YES NO | |

Do you have any disease or condition not listed? _____

WOMEN

Are you pregnant? YES NO Are you nursing? YES NO

FINANCIAL AGREEMENT

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the total balance on my account for any professional services rendered. Should my account become delinquent, I agree to pay interest at the rate of 1 1/2% per month (18% annual percentage rate). I also agree to pay all collection costs including attorney fees incurred. 33 1/3% will be added to accounts transferred out to collection.

Signature: _____ Date: _____

A CHARGE WILL BE MADE FOR APPOINTMENTS BROKEN
OR CANCELLED WITHOUT 48 HOURS ADVANCE NOTICE