Lisle dental center
Family, Cosmetic and Implant Dentistry
Changing Smiles For Life

Welcome to our office. Thank you for the confidence you place with us to provide your dental care. In order for us to best serve you, please complete the following form. This information will aid us in providing the best services to meet your dental needs. If any of this information changes at any point, please let us know. All info will be kept strictly confidential and not shared. If you have any questions, please don't hesitate to ask.

Name: _____Date of Birth: _____ Sex: ____ Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____Work : _____

Marital Status: Single | Married | Divorced | Separated | Widowed | Domestic Partner

Social Security: _____ Email: _____

Preferred Method of Contact: (Home | Cell | Work | Text | Email)

Favorite Pandora Station: _____ Favorite TV Show/Netflix: _____

How did you hear about our office: Google | Yelp | Friend | Drive By | Theaters | Insurance | Clipper

If by patient, name:_____

Person to contact In Case of Emergency:

Name: _____ Phone: _____Relationship: _____

Address:

_____

Has any member of your family been treated in our practice? Yes | NO If yes, Name: _____

Dental Insurance

Insured's Name: _____ DOB: _____ SS#: _____

Insured's Employer: _____

Insurance Company: _____

Insurance Address: _____

Phone Number: _____ Policy ID: _____ Group #: _____

Relationship to Patient: _____

Health Information

Patient's Name: _____ Date of Birth: _____

What is your main dental concern for today's visit? _____

Oral Health

1. Yes | No – Do you currently have any known dental problems?

2. Yes | No – Are any of your teeth sensitive to hot, cold, biting pressure, or sweets?
3. Yes | No – Do your gums bleed when brushing or flossing?
4. Yes | No – Have you ever been told you have periodontal (gum) disease?
5. Yes | No – Have you had a complete set of dental x-rays in the past year?
6. Yes | No – Do your jaw joints (TMJ) click, pop, or cause pain?
7. Yes | No – Do you clench or grind your teeth?
8. Yes | No – Have you had your wisdom teeth removed?
9. Yes | No – Have you ever thought of enhancing your smile with whitening?
10. Yes | No – Have you noticed any yellowing of your teeth?
11. Yes | No – Have you thought about enhancing your smile with BOTOX/Juvederm?
12. Yes | No – Do your teeth show signs of chipping and wear?
13. Yes | No – Do you have a replacement of any type for missing teeth?
14. Yes | No – Have you ever had Botox/Juvederm before?
15. Yes | No – Is there anything you would like to change about your smile?
    If Yes, please explain: _____
16. Tell us a little about your diet? Crave Sweets? Salty? Frequent Snacker? Soda Pop? Coffee? How often?
    _____ _____

Medical Health

Physician's Name: _____ Date of Last Visit: _____

1. Yes | No – Are you under the care of a physician now? If yes, reason(s)_____
2. Yes | No – Have you been hospitalized in the past 5 years? _____
3. Yes | No – Have you had any serious illnesses or operations? _____
4. Yes | No – Are you currently taking any medications? _____
5. Yes | No – Are you allergic to any medications or other substances? (Circle all that apply)
   Aspirin Penicillin Other Antibiotics Codeine Anesthetics Metals Latex Other_____
6. Do you have, or have you ever had, any of the following?

Yes | No-Any Heart Problems	Yes | No-Diabetes	Yes | No-Tuberculosis
Yes | No-Artificial Joints or Valves	Yes | No-Cancer/Tumor	Yes | No-Fainting Spells
Yes | No-Pacemaker	Yes | No-Excessive Bleeding	Yes | No-Epilepsy/Seizures
Yes | No-High Blood Pressure	Yes | No-AIDS/HIV	Yes | No-Thyroid Problems
Yes | No-Low Blood Pressure	Yes | No-Hepatitis	Yes | No-Psychiatric Treatment
Yes | No-Rheumatic Fever	Yes | No-Kidney Disease	Yes | No-Alzheimer's
Yes | No-Stroke	Yes | No-STDs	Yes | No-Drug Addiction

7. Yes | No – Do you have any disease, conditions, or condition not listed above? Please list _____
8. Yes | No – Do you require antibiotic premedication for dental treatment?
9. **Women:** (Circle if applicable) Pregnant | Nursing | Taking Birth Control
10. Is there anything else you would like for us to know about? _____

I certify that all the information above is correct to the best of my knowledge. I agree to notify this office of any changes to the above information as soon as reasonably possible.

Signature of patient (or legal guardian): _____ Date: _____