Basciano & Associates, PC

WELCOME

This information is important for us to know in planning your dental treatment. This information is, of course, confidential. Please fill out this form as completely as you can. Thank you!

Patient's Name:		Date of Birth:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		
Social Security #:	Email Address:		

For Child	
Father's Full Name:	Mother's Full Name:

For Adult ❑ **Mr.** ❑ **Mrs.** ❑ **Ms.** ❑ **Miss** ❑ **Dr.** ❑ **Other**	
Should the need arise may we contact you at work regarding your appointment? ❑ Yes ❑ No	Work Phone:
Patient's Employer:	Position/Department:
Spouse's Full Name & Employer	

Account Information (Insurance information on separate form)	
Name of person responsible for account:	Do you have dental insurance? ❑ Yes ❑ No
Employer:	
Name and Phone of person to contact in case of emergency:	
Whom may we thank for this referral?	

I hereby authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. The medical information on this form is accurate to the best of my knowledge.

Signature (parent or guardian if a minor): _____ Date: _____

Medical / Dental History	
Name & Address of Physician:	Date of Last Medical Visit:

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2932 Finley Road, Downers Grove, IL 60515
Phone (630) 629-6299 • Fax (630) 629-9738
dentalwellnesschicago.com

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Medical/Dental History (continued)
Are you now under the care of a physician? ❑ Yes ❑ No
If you answered yes above, for what reason?
List all medications, drugs and/or vitamin supplements with dosages that you are taking:

Please check any of the following that apply to you (now or in the past):

- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Artificial Heart Valve
- ❑ Congenital Heart Defect
- ❑ Abnormal Blood Pressure
- ❑ Ulcers
- ❑ Tuberculosis, Lung disease
- ❑ Diabetes
- ❑ Excessive urination, thirst
- ❑ Autoimmune Disease
- ❑ Epilepsy, Convulsions
- ❑ Anemia
- ❑ Thyroid Problem
- ❑ Chemical Dependency
- ❑ Abnormal Bleeding
- ❑ Fainting Spells
- ❑ Hepatitis
- ❑ Jaundice
- ❑ Asthma, Hay Fever
- ❑ Cancer
- ❑ Sinus problems
- ❑ Tumours - explain
- ❑ Stroke
- ❑ Glaucoma
- ❑ Radiation Therapy - explain
- ❑ Mental Health Care
- ❑ Knee or hip replacement
- ❑ Venereal Disease
- ❑ Arthritis
- ❑ Acid Reflux - GERD
- ❑ HIV
- ❑ Other
- ❑ Pregnant, due: _____
- ❑ Nursing
- ❑ Allergies:
  - ❑ Penicillin
  - ❑ Codeine
  - ❑ Local Anesthetic
  - ❑ Latex
  - ❑ Other _____
  - _____
  - _____
  - _____

When was your last dental cleaning?	Have you had dental x-rays taken in the last two years? ❑ Yes ❑ No
Are you aware of a dental problem? If yes, explain:	
In the past have you had any problems during dental appointments? ❑ Yes ❑ No	
If you answered yes above, please explain:	

Please check any of the following that apply to you (now or in the past):

- ❑ Gums bleed
- ❑ Gums disease
- ❑ Food collects
- ❑ Grinding or clenching
- ❑ Use tobacco products
- ❑ Jaw joint noise
- ❑ Locked jaw
- ❑ Unpleasant Taste
- ❑ Mouth sores
- ❑ Bite is off
- ❑ Teeth sensitive to sweets
- ❑ Teeth sensitive to cold
- ❑ Teeth sensitive to heat
- ❑ Teeth sensitive to pressure
- ❑ Chronic Headache
- ❑ Chronic neck pain
- ❑ Ear pain
- ❑ Teeth stain
- ❑ Braces
- ❑ Gum treatment

I have seen and read this Medical/Dental history. DDS Signature: _____ Date: _____

Medical Updates (STAFF USE) Note changes, date & sign.		
Date: ❑ No change ❑ see notes	Date: ❑ No change ❑ see notes	Date: ❑ No change ❑ see notes
Date: ❑ No change ❑ see notes	Date: ❑ No change ❑ see notes	Date: ❑ No change ❑ see notes

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INSURANCE - ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

Primary Carrier

Name of Insured: Date of Birth:

Employer: How long employed:

Name of Insurance Company:

Mailing Address:

Employee SS# or ID#: Group or Policy#:

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of the dental treatment.

Signature (patient or parent if minor): _____ Date: _____

I hereby authorize payment directly to the named dentist of the group insurance benefits otherwise payable to me.

Signature (patient or parent if minor): _____ Date: _____

Secondary Carrier

Name of Insured: Date of Birth:

Employer: How long employed:

Name of Insurance Company:

Mailing Address:

Employee SS# or ID#: Group or Policy#:

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of the dental treatment.

Signature (patient or parent if minor): _____ Date: _____

I hereby authorize payment directly to the named dentist of the group insurance benefits otherwise payable to me.

Signature (patient or parent if minor): _____ Date: _____

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