Halsted Dental Aesthetics

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Please Print

CHART NO. _____ (For Office Use only)

Patient Information

Patient Name: _____ Date: _____
Last First MI

Sex: ☐ M ☐ F ☐ Married ☐ Single ☐ Child ☐ Other_____ Drivers Lic. No. _____ State ____

Social Security #: _____ Birth Date: _____ **Email**: _____

Phone (Home): _____ (Work): _____ (Cell): _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐Th ☐S

Address: _____
Street Apt # City State Zip Code

Referral Information

Whom may we thank for referring you to our practice?

☐ Friend ☐ Relative ☐ Co-Worker ☐ Our Team ☐ Extreme Makeover ☐ Dentistinfo.com
☐ Halsteddental.com ☐ Chicago-Scene ☐ Chicago-Image ☐ Yellow Pages ☐ Other_____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

Relationship to Patient: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Subsciber: _____ Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

[Over]

Patient Name _____ (print)

Health Information

Pharmacy Name _____ Pharmacy Number _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV +
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint / Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Cold Sores/Blisters
- ☐ Congenital Heart Dis.
- ☐ Contact Lenses
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Hearing Problems
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis A B C O
- ☐ High/Low Blood Press
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
- Are you now under the care of a physician? ☐ Yes ☐ No Dr:_____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No

If any above are yes, please explain:_____

_____

Please check if you are presently taking any of the following:

- ☐ Antibiotics/Sulfa Drugs
- ☐ Anticoagulants (blood thinners)
- ☐ High Blood Pressure Medicine
- ☐ Cortisone or any other hormone medication
- ☐ Tranquilizers
- ☐ Antihistamines
- ☐ Aspirin
- ☐ Insulin, Tolbutamide (orinase) or similar drug
- ☐ Digitalis or drugs for heart trouble
- ☐ Nitroglycerin
- ☐ Oral Contraceptives
- ☐ Other_____

Please check if you are allergic or have reacted adversely to:

- ☐ Local Anesthetics
- ☐ Penicillin and other antibiotics
- ☐ Sulfa Drugs
- ☐ Barbiturates, sedatives or sleeping pills
- ☐ Aspirin
- ☐ Iodine
- ☐ Codeine or other narcotics
- ☐ Latex sensitivity
- ☐ Other_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Patient Name _____ (print)

Dental History

Date of Last Dental Visit: _____ Date of Last Cleaning: _____ Reason for this visit:_____

What was performed at your last dental visit? _____

How often do you floss? _____ How often do you brush? _____ What other dental items due you use? _____

Do you currently have any dental problems or concerns? _____

Are any of your teeth sensitive to?
☐ Hot ☐ Cold ☐ Sweets ☐ Biting/Chewing

Have you noticed any mouth odors or bad tastes? ☐ No ☐Yes
Do your gums bleed or hurt? ☐ No ☐Yes
Have your parents experienced gum disease or tooth loss? ☐ No ☐Yes
Have you noticed any loose teeth or change in your bite? ☐ No ☐Yes
Does food tend to become caught in between your teeth? ☐ No ☐Yes
If so? Where? _____
Do you mouth breath? ☐ No ☐Yes
Do you clench or grind your teeth? ☐ No ☐Yes
Drink alcohol / Smoke / Chew tobacco? ☐ No ☐Yes
How much and how long? _____

Have you ever had?

Braces ☐ No ☐Yes
Oral surgery? ☐ No ☐Yes
Gum Treatment? ☐ No ☐Yes
Implants? ☐ No ☐Yes
A night guard? ☐ No ☐Yes
Serious injury to mouth or head? ☐ No ☐Yes
If so? Explain _____

Had you ever experienced?

Clicking or popping of the jaw joints? ☐ No ☐Yes
Pain (ear, joint)? ☐ No ☐Yes
Difficulty opening or closing mouth? ☐ No ☐Yes
Difficulty chewing? ☐ No ☐Yes
Headaches, neck aches, shoulder aches? ☐ No ☐Yes
Sore muscles (Neck, shoulders)? ☐ No ☐Yes
A bite that feels uncomfortable or unusual? ☐ No ☐Yes
Ear or jaw pain upon waking? ☐ No ☐Yes

Why did you leave your previous dentist? _____
Are you interested in having whiter teeth? ☐ No ☐Yes
Are you happy with your smile? ☐ No ☐Yes
Is there anything you would change regarding your smile or overall facial appearance? ☐ No ☐Yes

Consent for Services

As a condition of your treatment by this office, we depend upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All dental services, scheduled or emergency, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services at time services are rendered. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. ***Dr. Widen IS NOT a participating provider with any insurance company!***

I understand that any fee estimate given for my dental care can only be extended for a period of thirty days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Regarding scheduled appointments:
This time is reserved specifically for you. In our practice we do not hop from room to room and schedule a bunch of patients at the same time. Our time is dedicated solely to you and you will seldom if ever have to wait. Because of this, however, it is very important that you don't miss any appointment. So please call us 48 hours in advance to reschedule if necessary. The one thing we can't accept in our office is missed or last minute cancelled appointments. Our individual dedicated scheduling is one of the things that make this practice so unique and special for our patients, but it also makes missed appointments catastrophic. **I understand that I will be charged a $50.00 fee (150.00 for Saturday) if I fail to show for my appointment, cancel or reschedule with less than a 48 hour (72 hour for Saturday) notice.**

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian