Welcome!!!

Pinckneyville Dental Care
1000 S Main Pinckneyville, IL 62274

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us, we will be happy to help.

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birth date _____ SSN# _____

Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Check appropriate box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

If Student, School/College _____ City _____ State _____ □ Full Time □ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Person to Contact in Case of Emergency _____ Home/Cell Phone _____

Nearest relative not living with you _____ Home/Cell Phone _____

Responsible Party

Name _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Drivers License # _____ Birth date _____ SSN# _____

Business Address _____ City _____ State _____ Zip _____

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth date _____ SSN# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE □ Yes □ No IF YES, COMPLETE THE FOLLOWING

Name of Insured _____ Relationship to Patient _____

Birth date _____ SSN# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID _____

Financial Responsibility

I understand that regardless of my assigned insurance benefits, I'm responsible for the total charges for services rendered and that I further agree that all amounts are due upon request and are payable to PDC, I further understand that should this account become delinquent and it becomes necessary for this account to be transferred to an attorney or collection agency for suit or collections, I, as the designated responsible party, shall pay the reasonable expenses for the suit or collections.

Signature _____

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? If you have a list please let the secretary know and she will make a copy for your records.		

_____
_____
_____
_____
_____
_____
_____

4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you wearing contact lenses?	☐	☐
7. Have you ever taken diet pills?	☐	☐

8. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Iodine	☐	☐
Sedatives	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury etc)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐

_____
_____
_____

9. Women Only:		
a) Are you Pregnant/think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

10. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pain	☐	☐	Diabetes	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐	Heart Trouble	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐	Cancer	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐	Glaucoma	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐	Arthritis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐	Leukemia	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Epilepsy/Convulsions	☐	☐	Kidney Diseases	☐	☐
Recent Weight Loss	☐	☐	Liver Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐
Joint Replacement/Implant	☐	☐				Sexually Transmitted Disease	☐	☐	Other_____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening, closing or chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions?	☐	☐
12. Have you ever had prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient (or parent/guardian of minor)