Meadows Dental Care
Personalized & Comfortable

4949 EUCLID AVE.
SUITE A
PALATINE, IL 60067
847/397-1111
Fax 847/397-1142

THANK YOU *for coming to our office for your dental care. In order for us to properly evaluate your dental and medical health, we request you to fill out **all** parts of this history form. Before any treatment or diagnostic procedures begin, we will inform you of our standard office practices and give you an opportunity to ask questions.*

GENERAL INFORMATION

DR. MISS MR. MS. MRS. PATIENT NAME FIRST MIDDLE LAST		BIRTH DATE	SOCIAL SECURITY #
DR. MISS MR. MS. NAME OF RESPONSIBLE PARTY - IF DIFFERENT FROM ABOVE	DRIVERS LICENSE #	STATE	SOCIAL SECURITY #
RESIDENCE ADDRESS NUMBER STREET			DATE OF BIRTH
CITY	STATE ZIP	EMAIL	
WORK PHONE HOME PHONE CELL PHONE		FULL TIME STUDENT YES ☐ NO ☐ WHERE	
OCCUPATION OF RESPONSIBLE PARTY	EMPLOYER		
BUSINESS ADDRESS NUMBER STREET			
CITY		STATE ZIP	
IN CASE OF EMERGENCY, PERSON TO NOTIFY (Not Living With You)		RELATIONSHIP	
WORK PHONE	HOME PHONE	CELL PHONE	
HOW WERE YOU REFERRED TO US?			

_____I have been offered a copy of Meadows Dental Care (MDC) Notice of Privacy Practices. I understand that MDC has the right to change its Notice of Privacy Practices from time to time and that I may contact MDC at any time to obtain a current copy of the Notices of Privacy Practices.

_____I authorize the release of my dental health information to my dental insurance companies. I hereby authorize payment directly to Meadows Dental Group, Ltd. of the group insurance benefits otherwise payable to me.

_____I understand and agree that I will be responsible to pay for missed appointment or insufficient cancellation notice fees of $50.00 per instance, and/or late charge fees of 1½ % per month/18 % per annum

_____I understand and agree in the event that this account goes past due and we are forced to use an outside collection agency or law firm, up to 30 % of the balance will be added as collection/ attorney's fees.

_____I understand and agree that if we are forced to file a lawsuit to collect the outstanding balance, you will be liable for all court costs whether judgment has been entered or not.

Signature_____Date_____

BENEFIT SECTION

NAME OF INSURANCE COMPANY			GROUP NUMBER	
ADDRESS OF INSURANCE COMPANY NUMBER STREET			INS ID#	
CITY		STATE	ZIP	
EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST		DATE OF BIRTH	EMPLOYEE/SUBSCRIBER SOC. SEC.#	
EMPLOYEE SUBSCRIBER MAILING ADDRESS	CITY	STATE	ZIP	
EMPLOYER (COMPANY) NAME AND ADDRESS				
IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	DENTAL PLAN NAME	GROUP NO.	INS ID #	
EMPLOYEE/SUBSCRIBER FIRST MIDDLE LAST		EMPLOYEE/SUBSCRIBER SOC. SEC.#	RELATIONSHIP TO EMPLOYEE SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	
EMPLOYER (COMPANY) NAME AND ADDRESS			DATE OF BIRTH	

Meadows Dental Care
Personalized & Comfortable

4949 EUCLID AVE.
SUITE A
PALATINE, IL 60067
847/397-1111
Fax 847/397-1142

DENTAL HISTORY

Purpose of this appointment: [] Cleaning & Check-up Exam [] Broken Tooth [] Pain

[] OTHER

_____

Date of last Dental Exam: _____

Do you wish your teeth were whiter? [ ] YES [ ] NO

Do you wish your teeth were straighter? [ ] YES [ ] NO

Have you ever injured your face, mouth, or teeth? [ ] YES [ ] NO

Do you habitually breathe through your mouth? [ ] YES [ ] NO

Do you sometimes find yourself tired throughout the day? [ ] YES [ ] NO

Has anyone told you that you occasionally snore? [ ] YES [ ] NO

Do you sometimes wake up after a full night of sleep still feeling groggy? [ ] YES [ ] NO

Do you often become out of breath after walking up a flight of stairs? [ ] YES [ ] NO

Are you likely to fall asleep at your desk, at a stop light, or watching TV? [ ] YES [ ] NO

Do you have seasonal allergies which cause you to have a stuffed nose? [ ] YES [ ] NO

Do you have any oral habits such as nail biting or chewing on pens? [ ] YES [ ] NO

Do you clench or grind your teeth? [ ] YES [ ] NO

Is your jaw ever sore or tired? [ ] YES [ ] NO

Have you ever been told or noticed if you have bad breath? [ ] YES [ ] NO

Have you ever noticed a bad taste in your mouth? [ ] YES [ ] NO

Do you catch food between any of your teeth? [ ] YES [ ] NO

Do your gums bleed when brushing or flossing? [ ] YES [ ] NO

Have you ever been told you have gum disease, gingivitis, or periodontitis? [ ] YES [ ] NO

Are any of your teeth sensitive? [ ] YES [ ] NO

IF YES, to what are they sensitive? [ ] HOT [ ] COLD [ ] SWEETS [ ] CHEWING

Are you nervous or anxious regarding dental treatment? [ ] YES [ ] NO

How frequently have you returned for dental checkups in the past?

[ ] Every 3 mos. [ ] Every 4 mos. [ ] Every 6 mos [ ] Every 12 mos.

Do you have any other dental issues, questions, or concerns?

_____

_____

_____

DENTAL INFORMATION

Meadows Dental Care

4949 EUCLID AVE.
SUITE A
PALATINE, IL 60067
847/397-1111
Fax 847/397-1142

MEDICAL HISTORY

1.) CARDIOVASCULAR SYSTEM: Do you have any cardiovascular/heart problems? [ ] NO **[ ]YES** _____

2.) ENDOCRINE: Do you have any endocrine (glandular) disorders? [ ] NO **[ ]YES** _____

3.) GASTROINTESTINAL Do you have any gastrointestinal/stomach problems? [ ] NO **[ ]YES** _____

4.) GENITOURINARY TRACT: Do you have any kidney or bladder problems? [ ] NO **[ ]YES** _____

5.) HEMATOLOGIC Do you have any hematologic/bleeding disorders? [ ] NO **[ ]YES** _____

6.) INFECTIOUS DISEASES: Do you have any infectious diseases? [ ] NO **[ ]YES** _____

7.) NEUROLOGICAL: Do you have any neurological problems? [ ] NO **[ ]YES** _____

8.) RESPIRATORY SYSTEM: Do you have any lung or breathing problems? [ ] NO **[ ]YES** _____

9.) Do you now or have you ever had any of the following conditions? **[ ] NO [ ] IF YES, PLEASE CHECK BELOW**

[ ] Allergies to Latex
[ ] Allergies to Medications:
LIST_____
[ ] Arthritis
[ ] Cancer
[ ] Diabetes
[ ] Eye/visual disorders:
(describe):_____
[ ] Headaches? # per week?_____
[ ] High Blood Pressure/Hypertension
[ ] Joint replacement
[ ] Liver problems
[ ] Multiple Sclerosis
[ ] Muscular Dystrophy
[ ] Osteoporosis
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Systemic Lupus Erythematosis
[ ] Do you snore loudly?
[ ] Excessive Daytime Sleepiness
[ ] Is your neck size larger than 16"?
[ ] Are you sleepy during the daytime?
[ ] Have you ever had a sleep study?
[ ] Do you have Sleep Apnea?

10.) **SOCIAL:**
Do you drink more than 2 alcoholic beverages per day? [ ] NO **[ ]YES** _____
Do you smoke tobacco? [ ] NO **[ ]YES** _____ # packs/day Do you chew tobacco products? [ ] NO **[ ]YES**

11.) **WOMEN:**
Are you pregnant? **[ ] YES** Date Due: _____ [ ] NO
Are you nursing? **[ ] YES** [ ] NO Are you taking Birth Control Pills? **[ ] YES** [ ] NO

12.) **OTHER: Do you have any other medical conditions not covered in this questionnaire?** **[ ] YES** [ ] NO
PLEASE LIST IF YES

_____

13.) Are you taking any medications including over the counter drugs? PLEASE LIST IF YES **[ ] YES** [ ] NO

_____

I verify that the information I have given is true and accurate to the best of my knowledge. I will not hold Meadows Dental Group, Ltd. its employees, staff, or my dentist responsible for any errors or omissions I may have made in the completion of this form. I authorize my dentist to release, request, and discuss my medical conditions with my physicians. After discussion with me, I authorize my dentist and any of his staff which he deems fit to take x-rays, study models, photographs or any other procedures necessary to make a complete and thorough diagnosis of my dental conditions. In case of emergency situations, I also authorize my dentist and any of his staff, which he seems fit, to perform any forms of treatment and render any medications which may be medically necessary or indicated.

_____ _____ _____
Signature of patient or legal guardian *Please Print Your Name & Relationship* *Date*

FOR OFFICE USE ONLY

Medical & Dental History reviewed by:

_____
Signature of dentist *Date*

SIGNIFICANT FINDINGS:

_____

_____

MEDICAL INFORMATION

Meadows Dental Care

Personalized & Comfortable

4949 EUCLID AVE.
SUITE A
PALATINE, IL 60067
847/397-1111
Fax 847/397-1142

MEDICAL HISTORY UPDATES:

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____

DATE:__________________ CHANGES ?______YES ______NO

IF YES, What?____