WELCOME…

Thank you for selecting our dental healthcare team! In order to give you the best of care, we provide state of the art dental techniques and technology. We also attend continuing education classes frequently to stay current on new techniques and ways to improve your dental care. Most importantly, we know your comfort and experience in our office is a priority. Please keep us informed on how we can best serve your needs. If you have any questions or need assistance in any way, please ask us–we will be happy to help you.

Patient Information

Name: ____________________ Date of birth: ____________ Nickname: ____________

Address: ____________________ City: ____________ State: ______ Zip: _____

Home Phone: ____________ Cell Phone: ____________ E-mail: ____________

Sex: ☐ Male ☐ Female   Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Minor

Would you like to receive appointment information via: ☐ Phone ☐ Email ☐ Text

Social Security Number: ____________ Who may we thank for referring you to our office? ____________

Patient's Employer: ____________________ Title: ____________

Business Address: ____________________ Work Phone: ____________ Ext: ________

Spouse Name (if applicable): ____________________

Spouse Employer: ____________________ Title: ____________

Address : ____________________ Work Phone: ____________

Person to contact in case of emergency: ____________________ Phone: ____________

Emergency Address: ____________________

Responsible Party

(if different than above)

Name of Person Responsible for this Account: ____________________ Relationship ____________

Address: ____________ Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

City: ____________ State: ______ Zip: ______ Social Security: ____________

Insurance Information

Are you covered under a dental insurance plan? ☐ YES ☐ NO
If yes, please complete the following . . .

Name of Insured: ____________________ Birthdate: ____________ Relationship to patient: ____________

Social Security Number: ____________ OR Individual ID# ____________ *(used by some* companies *in place of SS#)*

Name of Employer: ____________________ Group Number: ____________

Name of Insurance Company: ____________________

Address to send claims: ____________________

Telephone Contact: ____________________

Notice of Privacy Practices

Is described, in detail, on the reverse side of this form. A copy is provided for you to take home.

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 (insurance company). I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance 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 dependants. I further understand that a finance charge will be added to any balance over 30 days unless other terms have been negotiated.
I consent to the taking photographs of my teeth. I understand that these photographs will be a part of my medical record. They may also be used for educational purposes and professional publications. In such event, I will not be identified by name and I expect no compensation for these photographs.

Signature of patient (or parent, if minor): ____________________ Date: ____________

Alan H. Broadbent, DMD
303 Burwash Ave. Savoy, IL 61874   (217) 356-9855
www.SmileForUs.com
email: office@smileforus.com

Alan Broadbent, DMD

MEDICAL AND DENTAL HISTORY

Patient Name: ______________________

Reason for today's visit: ______________________

Name of previous dentist: ______________________

Approximate date of

- last dental exam: ______________________
- last cleaning: ______________________
- last x-rays: ______________________
- last oral cancer exam ______________________

How often do you brush?______ times a day. Floss? ___________

Check any of the following that apply to you:

- ☐ Require PRE-MEDICATION before dental treatment
- ☐ Teeth or gums bleed when brushing or flossing
- ☐ Teeth are sensitive to hot/cold or chewing
- ☐ Teeth sensitive to sweet/sour food or liquid
- ☐ I have a sore or lump in my mouth
- ☐ I have bad breath or dry mouth
- ☐ Clench or grind teeth
- ☐ Have frequent headaches
- ☐ Swollen or tender gums
- ☐ Food collects between teeth
- ☐ Would like whiter teeth

☐ Have you experienced any of the following in your jaw?

- ○ Clicking
- ○ Pain (joint, ear, side of face)?
- ○ Difficulty in opening or closing
- ○ Difficulty in chewing?

- ☐ Have mouth piercings
- ☐ History of smoking, chewing or use tobacco
  Type & frequency: ______________________
- ☐ Have had periodontal treatment (Gum Therapy)
  If so, when: ______________________
- ☐ Have any loose teeth or broken fillings?
  Please explain: ______________________
- ☐ Wear a denture or partial
  If so, date of placement: ______________________
- ☐ Have had orthodontic treatment (braces)
- ☐ I have old dental work that doesn't match or is breaking down.
  Please explain: ______________________

Please list sports that you play or other high impact activities:

____

____

Do you drink *(check all that apply)*

☐ Coffee ☐ Tea ☐ Wine

At home, do you get your water from

☐ City water lines ☐ Private well

Does dental treatment make you nervous?

☐ Yes ☐ No ☐ Not sure

Do you think your dental health affects your overall health?

☐ Yes ☐ No ☐ Not sure

How committed are you to saving your natural teeth?

Indifferent 1 2 3 4 5 Very Committed

IF I COULD CHANGE MY SMILE, I WOULD MAKE MY TEETH:

Whiter	☐ Yes	☐ No
Straighter	☐ Yes	☐ No
Close spaces	☐ Yes	☐ No
Repair chipped teeth	☐ Yes	☐ No
Replace missing teeth	☐ Yes	☐ No
Replace old crowns or caps	☐ Yes	☐ No
Replace dark silver fillings with tooth colored restorations	☐ Yes	☐ No

MEDICAL HISTORY

PATIENT NAME ____ Birth Date ___________________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________________
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________________
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________________
Are you on a special diet? ◯ Yes ◯ No ____________________
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ____________________

Do you have, or have you had, any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	◯	◯	Cortisone Medicine	◯	◯	Hemophilia	◯	◯	Renal Dialysis	◯	◯
Alzheimer's Disease	◯	◯	Diabetes	◯	◯	Hepatitis A	◯	◯	Rheumatic Fever	◯	◯
Anaphylaxis	◯	◯	Drug Addiction	◯	◯	Hepatitis B or C	◯	◯	Rheumatism	◯	◯
Anemia	◯	◯	Easily Winded	◯	◯	Herpes	◯	◯	Scarlet Fever	◯	◯
Angina	◯	◯	Emphysema	◯	◯	High Blood Pressure	◯	◯	Shingles	◯	◯
Arthritis/Gout	◯	◯	Epilepsy or Seizures	◯	◯	Hives or Rash	◯	◯	Sickle Cell Disease	◯	◯
Artificial Heart Valve	◯	◯	Excessive Bleeding	◯	◯	Hypoglycemia	◯	◯	Sinus Trouble	◯	◯
Artificial Joint	◯	◯	Excessive Thirst	◯	◯	Irregular Heartbeat	◯	◯	Spina Bifida	◯	◯
Asthma	◯	◯	Fainting Spells/Dizziness	◯	◯	Kidney Problems	◯	◯	Stomach/Intestinal Disease	◯	◯
Blood Disease	◯	◯	Frequent Cough	◯	◯	Leukemia	◯	◯	Stroke	◯	◯
Blood Transfusion	◯	◯	Frequent Diarrhea	◯	◯	Liver Disease	◯	◯	Swelling of Limbs	◯	◯
Breathing Problem	◯	◯	Frequent Headaches	◯	◯	Low Blood Pressure	◯	◯	Thyroid Disease	◯	◯
Bruise Easily	◯	◯	Genital Herpes	◯	◯	Lung Disease	◯	◯	Tonsillitis	◯	◯
Cancer	◯	◯	Glaucoma	◯	◯	Mitral Valve Prolapse	◯	◯	Tuberculosis	◯	◯
Chemotherapy	◯	◯	Hay Fever	◯	◯	Pain in Jaw Joints	◯	◯	Tumors or Growths	◯	◯
Chest Pains	◯	◯	Heart Attack/Failure	◯	◯	Parathyroid Disease	◯	◯	Ulcers	◯	◯
Cold Sores/Fever Blisters	◯	◯	Heart Murmur	◯	◯	Psychiatric Care	◯	◯	Venereal Disease	◯	◯
Congenital Heart Disorder	◯	◯	Heart Pace Maker	◯	◯	Radiation Treatments	◯	◯	Yellow Jaundice	◯	◯
Convulsions	◯	◯	Heart Trouble/Disease	◯	◯	Recent Weight Loss	◯	◯			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ____________________

Comments: ____________________
____
____
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ____________