

Welcome!



Winnetka Dental Associates
Genuine. Caring. Excellence.
EST. 1962

Patient Information (CONFIDENTIAL)

Today's Date _____

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell Phone _____

Minor Single Married Divorced Widowed Home Phone _____

If minor, name of Parent/Guardian _____ Phone _____

Person to contact in case of emergency _____ Phone _____

Whom may we thank for referring you? _____

Responsible Party Check box if same as above

Name of Person Responsible for this Account _____

Relationship to Patient _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Email _____

Cell Phone _____ Home Phone _____

Whom may we thank for referring you? _____

Insurance Information

Name of Insured _____ Birthdate _____

Relationship to Patient _____ SS# _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy ID# _____

Ins. Co Address _____ City _____ State _____ Zip _____

Patient Medical Information *Please check yes or no. If yes, please provide details.*

Are you under the care of a physician now? Yes No _____

Have you ever been hospitalized or had a major operation? Yes No _____

Have you ever had a serious head or neck injury? Yes No _____

Are you taking any medications, pills, or drugs? Yes No _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No _____

Do you use controlled substances? Yes No _____

Women only - Check if you are... Pregnant/trying to get pregnant Nursing Taking oral contraceptives

Are you allergic to any of the following medications? Aspirin Penicillin Codeine Acrylic

Metal Latex Sulfa Drugs Local Anesthetics Other _____

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

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

Have you ever had any serious illness not listed above? Yes No

If yes, please explain _____

Signature of Patient, Parent or Guardian _____ Date _____