Patel MEDICAL ESTHETICS & FAMILY DENTISTRY
Your one-stop shop for affordable family healthcare

Smita B. Patel DDS
9663 Franklin Avenue
Franklin Park, IL 60131
Phone: 847-455-4750
Web: www.PatelFamilyDentist.com

DENTAL REGISTRATION

PATIENT INFORMATION

Patient Name ____ Date _______________
Last *First* *MI*

Preferred Name_________________________________ Social Security No. ________________

Male ❑ Female ❑ Married ❑ Single ❑ Child/ren ❑ Birth date ____________ Age_______________

Driver's License No. ________________ e-Mail Address ________________________________

Patient's Address ____
Street *City* *St* *Zip*

Home phone ________________________ Work phone____________________ Ext _________

Cell phone__________________________ Best Time to Call__________ Fax ______________

Preferred appointment times Morning ❑ Afternoon ❑ Evening ❑ Any Time ❑ M ❑ T ❑ W ❑ Th ❑ F ❑

Student Status / College Attending ____

EMPLOYMENT INFORMATION

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

Employer Name ______________________ Occupation _________________ Years Employed _____

Patient's Address ____
Street *City* *St* *Zip*

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name ____ Date _______________
Last *First* *MI*

Male ❑ Female ❑ Married ❑ Single ❑ Birth date __________ Age ____ Social Security No.____________

Driver's License No. ________________ e-Mail Address ________________________________

Address____
Street *City* *St* *Zip*

Home phone ________________________ Work phone____________________ Ext _________

Cell phone__________________________ Best Time to Call __________ Fax ______________

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?_________________________________
Name of person or office referring you to our practice

❑ Another patient ❑ Friend ❑ Relative ❑ Internet ❑ Dental Office
❑ Yellow Pages ❑ Newspaper ❑ School ❑ Work ❑ Location Other _______________

PRIMARY INSURANCE

Insured's Name ____

Insurance Company __________________________ Insurance Company Phone No. ____________

Insurance Company Address ____

Insured's Employer ____

Insured's Birth Date ________________ Social Security No. __________ ID No. _______________

Group No. ______________________ Patient's relationship to insured ❑ Self ❑ Spouse ❑ Child ❑ Other

SECONDARY INSURANCE

Insured's Name ____

Insurance Company __________________________ Insurance Company Phone No. ____________

Insurance Company Address ____

Insured's Employer ____

Insured's Birth Date ________________ Social Security No. __________ ID No. _______________

Group No. ______________________ Patient's relationship to insured ❑ Self ❑ Spouse ❑ Child ❑ Other

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Smita B. Patel

*Signature*____ *Date* ____________________

Patel MEDICAL ESTHETICS & FAMILY DENTISTRY
Your one-stop shop for affordable family healthcare

Smita B. Patel DDS
9663 Franklin Avenue
Franklin Park, IL 60131
Phone: 847-455-4750
Web: www.PatelFamilyDentist.com

DENTAL HISTORY

HOW LONG since you have seen a dentist? ________________ Last COMPLETE Dental Exam DATE __________

REASON for this Visit __________________________________ Last FULL MOUTH X-RAYS DATE ____________

What do you LIKE or DISLIKE about your previous dental experience? ____________________________________

GENERAL

- Do you or have you ever been diagnosed with SLEEP APNEA? Yes ❑ No ❑
- Is your dental health POOR? Yes ❑ No ❑
- Do you wear DENTURES? (Partials or Fully)? Yes ❑ No ❑
- Are you APPREHENSIVE about Dental Treatment? Yes ❑ No ❑
- Have you had any PERIDONTAL (gum) treatments? Yes ❑ No ❑
- Is your teeth SENSITIVE to hot, cold, sweets, pressure? (circle those that apply) Yes ❑ No ❑
- Are you aware of grinding or clenching your teeth? Yes ❑ No ❑
- Do you have HEADACHES, EARACHES, or NECK PAINS? Yes ❑ No ❑
- Have you worn BRACES on your teeth? (ORTHODONTICS)? Yes ❑ No ❑
- Do you REGULARLY use DENTAL FLOSS? Yes ❑ No ❑

PERIODONTAL DISEASE

Is painless…and often victims are unaware they have the disease. It affects 3 out of 4 in the USA.

- Are your gums red, swollen, or tender? Yes ❑ No ❑
- Are your gums pulling away from your teeth? Yes ❑ No ❑
- Do you see pus between your teeth and when your gums are pressed? Yes ❑ No ❑
- Do your gums bleed when you brush your teeth or toothpick between them? Yes ❑ No ❑
- Are your permanent teeth loose or separating? Yes ❑ No ❑
- Is there any change in the way your teeth fit when you bite? Yes ❑ No ❑
- Is there any change in the fit of your partial dentures? Yes ❑ No ❑
- Do you have bad breath and bad taste? Yes ❑ No ❑

How do you FEEL about your teeth? ____
Are you PLEASED with the APPEARANCE of your teeth? ____
What would you LIKE TO CHANGE about your teeth? ____

Please rank the following in order in which they would KEEP YOU FROM having dental treatment.
(1,2,3,4 – 1 being the main reason)

__ Fear Of Pain # ___ Cost Of Treatment # ____ Lack Of Concern # ____ Missing Work Time

DENTAL TREATMENT

- Do you require pre-medication before dental treatment? Yes ❑ No ❑ If yes, explain ______________________
- Have you ever had any complications following dental treatment? Yes ❑ No ❑ If yes, explain ______________________
- Are you currently taking any medication or drugs?
- Have you ever taken Phen fen? Yes ❑ No ❑ If yes, explain ______________________
- Have you been admitted to a hospital during past two years? Yes ❑ No ❑ If yes, explain ______________________
- Are you under the care of a physician? Yes ❑ No ❑ If yes, name of Dr. ___________________

Patel
MEDICAL ESTHETICS
& FAMILY DENTISTRY
Your one-stop shop for affordable family healthcare

Smita B. Patel DDS
9663 Franklin Avenue
Franklin Park, IL 60131
Phone: 847-455-4750
Web: www.PatelFamilyDentist.com

MEDICAL HISTORY

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

❑ AIDS
❑ Allergies ____________
____
❑ Anemia
❑ Arthritis
❑ Artificial Joints
❑ Asthma
❑ Blood Disease
❑ Cancer
❑ Diabetes
❑ Dizziness
❑ Epilepsy
❑ Excessive

❑ Fainting
❑ Glaucoma
❑ Growths
❑ Hay Fever
❑ Head Injuries
❑ Heart Disease
❑ Heart Murmur
❑ Hepatitis
❑ High Blood Pressure
❑ Jaundice
❑ Kidney Disease
❑ Liver Disease
❑ Mental Disorders

❑ Stomach Problems
❑ Mitral Valve Prolapse
❑ Nervous Disorders
❑ Pacemaker
❑ Pregnancy
if yes, due date ___________
❑ Prosthesis_________________
if yes, list _______________
❑ Radiation Treatment
❑ Respiratory Problems
❑ Rheumatic Fever
❑ Rheumatism
❑ Sinus Problems

❑ Stroke
❑ Tuberculosis
❑ Tumors
❑ Ulcers
❑ Venereal Disease
❑ Aspirin Allergy
❑ Codeine Allergy
❑ Novocaine
❑ Penicillin Allergy
❑ OTHER __________
____
❑ Latex Allergy

Is there any other Medical or Dental information that you feel I should know? ________________________________
____
____
____
____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any change in my medical status. I authorize the dental staff to perform consent that I may need during diagnosis and treatment.

Signature____ Date _________________________

Print Name ____