

# GETTING TO KNOW YOU...

DENTAL AND MEDICAL HISTORY + REGISTRATION FORMS



FAMILY DENTAL CARE  
OF OAK PARK



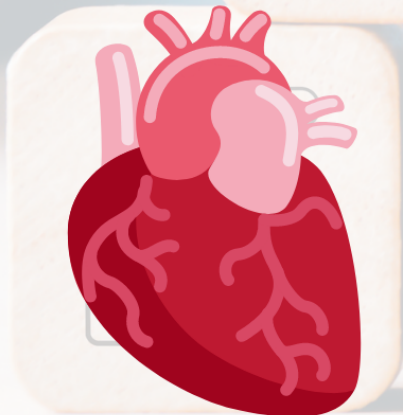
FAMILY DENTAL CARE  
OF OAK PARK

WELLNESS CENTER

NUTRITION

WEIGHT LOSS

HEALTH





## Patient Demographics

**Patient Info:**

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
@aol @gmail @yahoo @hotmail @sbcglobal

Preferred Pronouns: \_\_\_\_\_

**Responsible Party:**  **\*Check this box if patient is responsible party\***

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
@aol @gmail @yahoo @hotmail @sbcglobal

Relationship to patient: \_\_\_\_\_

I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third-party payors and/or other healthcare practitioners. I authorize and hereby request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. 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 remaining balances. \_\_\_\_\_ (Initial here)

**Dental Insurance Info:**  **\*Check this box if you do not have dental insurance\***

**\*Check this box if you would like to learn about our in-office member savings program\***

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Subscriber Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_



**Medical Insurance Info:**

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Subscriber Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**How would you like to receive reminders for future appointments?**

Text \_\_\_ Phone \_\_\_ Email \_\_\_ None \_\_\_

**Authorization and Release**

I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my dependants during the period of such dental care to third-party payors and/or other healthcare practitioners. I authorize and hereby request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. 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 remaining balances

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Dental-Staff

# Medical History

Although dental personnel primarily treat the area in and around the mouth, it is apart of your entire body. Health problems that you may have could have an important interrelationship with the dentistry you will be receiving at this office. Thank you for answering the following questions.

**Medical Doctor's Information:**

Primary Physician: _____
Nurse Practitioner: _____
Phone Number: _____ Fax: _____
Hospital Affiliation: _____
Address: _____

**Medications:**

Please list all medications, vitamins and supplements you currently taking:	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Allergies: Please circle yes or no if you have had a reaction to, or are allergic to the following:**

Allergy:	Yes	No	Allergy:	Yes	No
Penicillin			Aspirin		
Tetracycline			Acetaminophen		
Erythromycin			Ibuprofen		
Clindamycin			Cephalosporins		
Local Anesthetic			Codeine		
Sulfa			CT Contrast		
Iodine			Latex/Rubber/Vinyl		
Nuts/Fruit			Metals (Gold, Silver, Nickel)		
Barbiturates/Sedatives			Gluten		

Please list any other allergies you have here: \_\_\_\_\_

<b>Do you use any of the following?</b>	Yes	No
Marijuana		
Tobacco		
Blood Thinners		

<b>Personal History - Surgical</b>	Yes	No
Have you ever had a surgical procedure or operation?		
Have you had any reactions to sedation medications?		
Were there any complications during the procedure or operation?		
Have you ever had a joint replacement or implant?		
Have you ever had an organ transplant?		

<b>Heart History - Cardiovascular</b>	Yes	No
Have you ever been diagnosed with Cardiovascular Disease?		
Have you ever been diagnosed with Rheumatic Fever or Scarlet Fever?		
Have you ever been diagnosed with a heart defect or a heart murmur?		
Have you ever experienced a heart attack, angina or other heart troubles?		
Do you experience shortness of breath?		
Do you experience chest pain?		
Do you have a pacemaker?		
Have you ever had a mitral valve prolapse?		
Do you have High or Low blood pressure?		
Have you ever had a blood clot?		
Have you been diagnosed with Type 1 or Type 2 diabetes? If yes, which one?		
Have you had any other heart surgeries?		

<b>Cancer History - Oncology</b>	Yes	No
Have you ever been diagnosed with cancer?		
Are you currently going through chemotherapy or immunotherapy?		
Are you currently going through radiation treatments?		
Have you had any surgeries related to cancer?		
Do you experience side effects as a result of cancer treatments?		
Have you ever had any lymph nodes removed surgically due to cancer metastases?		

<b>Brain History - Neurological</b>	Yes	No
Have you been diagnosed with a neurological condition?		
Have you ever had epilepsy or seizures?		
Do you experience fainting or dizzy spells?		
Have you ever had a stroke?		
Have you ever had tumors?		
Have you ever been diagnosed with Alzheimer's or dementia?		
Have you ever had a head, neck or jaw injury?		
Do you have issues falling or staying asleep?		

<b>Airway History - Respiratory</b>	Yes	No
Have you ever been diagnosed with a respiratory condition?		
Do you experience shortness of breath?		
Do you experience lung/breathing problems?		
Have you ever been diagnosed with asthma or hay fever?		
Do you have a persistent cough?		
Do you have a cough that produces blood?		



<b>Belly History - Gastrointestinal</b>	Yes	No
Have you ever been diagnosed with a gastrointestinal condition?		
Have you ever been diagnosed with Irritable Bowel Syndrome?		
Have you ever had a stomach ulcer?		
Do you have, or have you had any teeth removed, or never developed?		
Do you tend to crave sweets?		
Do you have acid reflux?		

<b>Hormone History - Endocrine</b>	Yes	No
Have you ever been diagnosed with an endocrine condition?		
Have you ever been diagnosed with hyperthyroidism or hypothyroidism?		
Do you have water retention or swelling?		
Do you find you are easily irritated		
Are you unable to lose weight?		

<b>Immune History - Lymphatic</b>	Yes	No
Have you ever been diagnosed with an auto-immune condition?		
Have you ever been diagnosed with systemic lupus?		
Do you experience swelling in your hands, legs or feet?		
Have you had the SARS-CoV 2 virus?		
Have you been vaccinated for the SARS-CoV 2 virus?		

<b>Mental Health History</b>	Yes	No
Have you ever been diagnosed with a mental health condition?		
Do you experience nervousness or anxiety?		
Do you experience depression?		
Do you have a chemical dependency		



<b>Women's Health</b>	Yes	No
Are you pregnant or trying to become pregnant?		
Do you use oral contraceptives?		
Do you use other forms of birth control?		
Do you have a menstrual cycle		
If you do not, have you had a hysterectomy or oophorectomy?		
Are you currently breastfeeding?		
Have you had pregnancy complications?		
Are you taking any hormone replacement pills or creams		
Have you ever come in contact with an STI?		
Have you ever been diagnosed with HIV or AIDS?		

<b>Men's Health</b>	Yes	No
Have you ever experienced ED?		
Have you ever been diagnosed with prostate cancer?		
Have you ever come in contact with an STI?		
Have you ever been diagnosed with HIV or AIDS?		

<b>Nutrition - Wellness</b>	Yes	No
Are you overweight?		
Have you ever been diagnosed with anorexia?		
Have you ever been diagnosed with bulimia?		
Have you ever been diagnosed with an eating disorder		
Have you ever had nutrition counseling?		
Do you eat or drink candy/sugary snacks or soda/pop/sugary beverages?		
Have you ever been diagnosed with osteoporosis		

<b>Virus History - COVID</b>	Yes	No
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Have you been diagnosed with Covid-19 in the last 14 days?		
Have you been vaccinated for Covid-19? If yes, which one did you receive?		
Have you ever been diagnosed with mono, strep, or herpes simplex virus?		
Have you ever been diagnosed with chickenpox, tuberculosis or measles?		
Would you like us to do a rapid Covid-19 test today?		

Are there any other medical diagnoses that you've received not listed above?

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Is there anything else that you'd like us to know about you?

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## Dental History

<b>Personal History:</b>	Yes	No
Have you ever had an unfavorable dental experience?		
Have you ever had complications during a past dental treatment?		
Have you ever used Nitrous Oxide or Laughing Gas?		
Have you ever had an Oral-Bacteria Risk Assessment?		
Have you ever had any reactions to, or trouble getting numb with Local Anesthetic?		
Have you noticed any lumps in or around your mouth?		
Do you have, or have you had any teeth removed, or never developed?		
Have you ever had orthodontic treatment, braces, or bite adjusted?		
Do you currently have any pain in your teeth?		

<b>Gum and Bone History - Periodontal</b>	Yes	No
Do your gums bleed or hurt when brushing/flossing?		
Have you ever been told you have gum disease or losing bone around teeth?		
Have you ever noticed an unpleasant smell or taste in your mouth?		
Does anyone in your family have a history of periodontal disease?		
Have you noticed any gum recession? (The tooth looks longer)		
Have you had any teeth become loose on their own?		
Have you ever had gum surgery?		

<b>Tooth Structure History - Cavities</b>	Yes	No
Have you had any cavities in the last 3 years?		
Are your teeth sensitive to hot/cold/sweet/salty? Do you avoid brushing in those areas?		
Do you have grooves or notches near the gumline?		
Does food tend to get stuck between your teeth?		

<b>Occlusion History - Bite, Jaw, and TMJ</b>	Yes	No
Do you have issues with your jaw joint (popping, clicking, locking, cracking etc)		
Do you avoid chewing gum, nuts, carrots, hard or chewy foods?		
Have your teeth changed in the last 5 years becoming shorter, thin or worn?		
Are your teeth becoming more crooked, overlapped or crowded?		
Have you ever had orthodontic treatment, braces, or bite adjusted?		
Do you have more than one bite, squeeze or shift to make your teeth fit together?		
Do you clench or grind your teeth, morning or night, and end up with a headache?		
Do you wear or have you ever worn a bite appliance?		



<b>Cosmetic History - Smile</b>	Yes	No
Is there anything about the appearance of your smile you'd like to change?		
Have you ever had your teeth whitened?		
Have you ever felt uncomfortable or self-conscious about the appearance of your smile?		
Have you been disappointed about the appearance of dental work?		

What can we do as a part of your healthcare team, to ensure you have an excellent experience in our dental practice?

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### **Authorization and Release**

I certify that I have read and understand the above information to the best of my knowledge. The questions have been answered accurately and I understand that providing false information can result in damaging my health. I authorize the dentist to release any information including the diagnoses and records of any treatment or examination rendered to me or my child during the period of such dental care to third-party payors/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 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 dependents.

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Dr. James E Scapillato D.D.S**