Medical & Dental History/ Customer Service Registration

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

**MEDICAL HISTORY**

Although dentists typically treat the area in and around your mouth, the mouth is an integral part of your body. Health problems that you may have, or medication you are taking, could have an important effect on the dentistry you will receive.

1. Please describe your general health?\_\_\_\_\_Excellent \_\_\_\_\_Good \_\_\_\_\_Fair \_\_\_\_\_Poor
2. How interestd are you in learning how oral health affects your overall health? \_\_\_\_\_Very interested \_\_\_\_\_somewhat interested \_\_\_\_\_Not now, maybe later \_\_\_\_\_Not interested
3. Do you have a regular physician? \_\_\_\_\_Yes \_\_\_\_\_No If yes, Name & #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Are you on a special diet? \_\_\_\_\_No \_\_\_\_\_Yes ; If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Have you been hospitalized or had an operation?\_\_\_\_\_No \_\_\_\_\_Yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Are you taking any prescription medications? \_\_\_\_\_No \_\_\_\_\_Yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Are you taking any vitamins or supplements? \_\_\_\_\_No \_\_\_\_\_Yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Are you allergic to any of the following?

\_\_\_\_\_Aspirin \_\_\_\_\_Penicillin \_\_\_\_\_Erythromycin

\_\_\_\_\_Latex \_\_\_\_\_Acrylic \_\_\_\_\_Codeine

\_\_\_\_\_Sulfa \_\_\_\_\_Dental Anesthetics \_\_\_\_\_Tetracyline

\_\_\_\_\_Metals (in jewelry) \_\_\_\_\_Other, Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you smoke? \_\_\_\_\_NO \_\_\_\_\_YES, how much & for how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. WOMEN ONLY: Do you take oral contraceptives? \_\_\_\_\_NO \_\_\_\_\_YES

 Are you pregnant? \_\_\_\_\_NO \_\_\_\_\_\_YES, how many weeks:\_\_\_\_\_\_\_\_\_\_

 Are you nursing? \_\_\_\_\_NO \_\_\_\_\_\_YES

1. Please check any of the following that you have had or currently have:

\_\_\_\_\_Abnormal Bleeding/Hemophilia \_\_\_\_\_Cardiovascular Disease \_\_\_\_\_Allergies

\_\_\_\_\_Hepatitis \_\_\_\_\_Anemia \_\_\_\_\_High Blood Pressure

\_\_\_\_\_Arthritis/Gout \_\_\_\_\_Low Blood Pressure \_\_\_\_\_\_Asthma

\_\_\_\_\_HIV/AIDS \_\_\_\_\_Cancer-Chemotherapy-Radiation \_\_\_\_\_\_Rheumatic Fever

\_\_\_\_\_Colitis \_\_\_\_\_Sinus Problems \_\_\_\_\_Congenital Heart Defect

\_\_\_\_\_Thyroid Problems \_\_\_\_\_Diabetes \_\_\_\_\_Ulcers

\_\_\_\_\_Emphysema \_\_\_\_\_Skin Disorders \_\_\_\_\_Epilepsy

\_\_\_\_\_Heart Disease, Pacemaker/ Artificial Valves

\_\_\_\_\_Other, Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been told you snore or been diagnosed with sleep apnea?

 \_\_\_\_\_NO \_\_\_\_\_Yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. SNORING: do you snore loudly (louder than talking or enough to be heard through a closed door)? Y N
2. TIRED: Do you often feel tired, fatigued or sleepy during the day? Y N
3. OBSERVED: Has anyone observed you stop breathing during your sleep? Y N
4. BLOOD PRESSURE: Do you have or are you being treated for high blood pressure? Y N

**DENTAL HISTORY**

1. Approximate date of your last dental visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What was completed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How do you describe your dental health? \_\_\_\_\_excellent \_\_\_\_\_good \_\_\_\_\_fair \_\_\_\_\_poor
3. How do you rate your dental hygiene? \_\_\_\_\_excellent \_\_\_\_\_good \_\_\_\_\_fair \_\_\_\_\_poor
4. What does your oral hygiene routine consist of? \_\_\_\_\_brushing \_\_\_\_\_flossing \_\_\_\_\_\_mouthrinse

OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please check any of the following dental treatments you have had:

\_\_\_\_\_orthodontics (braces, Invisalign, retainers) \_\_\_\_\_wisdom teeth removal

\_\_\_\_\_endodontics (root canals) \_\_\_\_\_periodontal treatment (gum surgery)

\_\_\_\_\_TMJ treatment \_\_\_\_\_Partials/Bridges

\_\_\_\_\_treatment for tooth grinding and/or cleaning

OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please check any of the following you are CURRENTLY experiencing?

\_\_\_\_\_sensitivity to hot \_\_\_\_\_sensitivity to cold \_\_\_\_\_sensitivity to sweets

\_\_\_\_\_sensitivity to chewing \_\_\_\_\_chipped teeth \_\_\_\_\_crooked teeth

\_\_\_\_\_spaces between teeth \_\_\_\_\_food catching \_\_\_\_\_bleeding gums

\_\_\_\_\_receeding gums \_\_\_\_\_bad breath \_\_\_\_\_frequent cold sores

\_\_\_\_\_frequent canker sores \_\_\_\_\_teeth clenching or grinding \_\_\_\_\_sore gums

 OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CUSTOMER SERVICE (please circle all that apply)**

1. What is the best way to contact you? Email Home # Work# Cell# Regular Mail
2. If leaving test results or reminders for needed treatment? Email Home # Work# Cell# Regular Mail
3. What brought you in today (check all that apply)?

\_\_\_\_\_prompt appointments \_\_\_\_\_trust treatment recommendations \_\_\_\_\_convenient

\_\_\_\_\_they are nice \_\_\_\_\_competent \_\_\_\_\_offer options

\_\_\_\_\_offer clear explanations \_\_\_\_\_referral \_\_\_\_\_financial options

OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What level of dental care of your looking for? There is no right or wrong answer.

\_\_\_\_\_tell me everything (cosmetic, preventive, elective)

\_\_\_\_\_emergency care only (relieve my pain & symptoms)

 \_\_\_\_\_basic (keep my teeth healthy, but I’m not really interested in anything elective/cosmetic at this time)

 \_\_\_\_\_needed (keep recommendations to things that are urgent only)

 \_\_\_\_\_\_depends (will my insurance cover it and I haven’t met you yet.)

Thank you for filling this out. I founded my practice on extraordinary customer service. This information helps me give you a customized dental experience that not should not only meet your expectations but exceed them. Welcome!