DAVID SHONBERG, D.D.S.
30 N. MICHIGAN AVE., #1503
CHICAGO, IL 60602
(312) 726-1901

Welcome

MILLENNIUM PARK PROSTHODONTICS

To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____
SS#/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Name _____ *Birthdate* _____ *Home Phone* _____
Address _____ *City* _____ *State/Prov.* _____ *Zip/P.C.* _____
Email _____ *Cell Phone* _____
Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*
If Student, Name of School/College _____ *City* _____ *State/Prov.* _____ ☐ *Full Time* ☐ *Part Time*
Patient or Parent/Guardian's Employer _____ *Work Phone* _____
Address _____ *City* _____ *State/Prov.* _____ *Zip/P.C.* _____
Spouse or Parent/Guardian's Name _____ *Employer* _____ *Work Phone* _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ *Phone* _____

Responsible Party

Name of Person Responsible for this Account _____ *Relationship to Patient* _____
Address _____ *Home Phone* _____
Email _____ *Cell Phone* _____
Driver's License # _____ *Birthdate* _____ *Financial Institution* _____
Employer _____ *Work Phone* _____ *SS#/SIN* _____
Is this person currently a patient in our office? ☐ *Yes* ☐ *No*
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ *Cash* ☐ *Personal Check* *Credit Card* ☐ *VISA* ☐ *MasterCard* ☐ *I wish to discuss the office's payment policy.*

Insurance Information

Name of Insured _____ *Relationship to Patient* _____
Birthdate _____ *SS#/SIN* _____ *Date Employed* _____
Name of Employer _____ *Union or Local #* _____ *Work Phone* _____
Address of Employer _____ *City* _____ *State/Prov.* _____ *Zip/P.C.* _____
Insurance Company _____ *Group #* _____ *Policy/ID #* _____
Ins. Co. Address _____ *City* _____ *State/Prov.* _____ *Zip/P.C.* _____
How much is your deductible? _____ *How much have you used?* _____ *Max. annual benefit* _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ *Yes* ☐ *No* *IF YES, COMPLETE THE FOLLOWING:*

Name of Insured _____ *Relationship to Patient* _____
Birthdate _____ *SS#/SIN* _____ *Date Employed* _____
Name of Employer _____ *Union or Local #* _____ *Work Phone* _____
Address of Employer _____ *City* _____ *State/Prov.* _____ *Zip/P.C.* _____
Insurance Company _____ *Group #* _____ *Policy/ID #* _____
Ins. Co. Address _____ *City* _____ *State/Prov.* _____ *Zip/P.C.* _____
How much is your deductible? _____ *How much have you used?* _____ *Max. annual benefit* _____

Over Please

Patient Medical History

Physician _____ *Office Phone* _____ *Date of Last Exam* _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking?	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other_____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ *Date of Last Exam* _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement_____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

X _____

Signature of patient (or parent/guardian if minor) *Date*

Doctor's Comments

Signature _____ *Date* _____

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