Orchard Crossing
2090 ORCHARD RD.
MONTGOMERY, IL 60538

(630) 859-3550

info@orchardcrossingdentistry.com

Patient Information

Patient Name:____Date:_____________
Last, First MI (Preferred Name)

Birth Date:___________Gender: F____ M____ Social Security #: ____________________

Phone (Home):_______________________________(Cell): ___________________________

Address:____
Street Apartment #

____
City State Zip Code

Status- Check one: ☐ Single ☐ Married ☐ Divorced ☐Widow ☐Child

Employer______________________________________Phone_______________Ext.__________

Employer Address____
City State Zip Code

Guarantor/Spouse's Name ____

Guarantor/Spouse's Employer ____

Guarantor/Spouse's Birth Date_______________Guarantor/Spouse Social Security #_______________

Emergency Contact:

Name__________________________Phone_________________Relationship to Patient_______________

Address____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐Th ☐F ☐ S

Preferred confirmation methods: ☐ E-mail ☐ Text ☐ Both Email Address:_______________________________

Section 2: Minor

Child resides with: Mother_____Father_____Both_____Legal Guardian___________________________
Relationship to Child

Mother's Name________________________________Address___________________________________
If different than above

Phone_________________________Birthdate___________Social Security #________________________

Father's Name________________________________Address___________________________________
If different than above

Phone_________________________Birthdate___________Social Security #________________________

18 years and older: Full time Student Yes or No School Attended_________________________

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend/ relative ☐ Dental Office

☐ Mailer ☐ Insurance ☐Website ☐Advertisement ☐ Work ☐ Other _________________________

Name of person or office referring you to our practice: _____________________________________

Continued on Side 2

Insurance Information

Primary

Name of Insured:____________________________Insured's Birth Date:_________SS #:__________________

Insured's Employer Name: ____ Group ID #: _________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_________________________________

Insurance Plan Name and Address:___________________________________Phone ____________________

____

Dental History

Please check any of the following problems that apply to you.

- Sensitivity (hot, cold, sweet)
  Where? UR LR UL LL
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

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

- Night Guard
- Braces
- Deep Cleaning / Gum treatments
- Dentures / Partial Dentures

Please share the following dates:

Your last cleaning____/_______

Your last complete X-Rays____/______

Name of Previous Dentist___________________

Phone Number____________________________

What is the most important thing to you about your future smile and dental health?

____

____

Do you smoke or use chewing tobacco?

How much?____For how long?_________

I would like to discuss the following for my smile:

- A Whiter Smile
- A Straighter Smile
- Closing spaces
- Replacing black metal fillings with tooth colored restorations
- Replacing missing teeth
- Repairing chipped teeth
- Replacing old crowns that don't match
- Having a smile makeover

On a scale of 1 — 10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

____

What did you like best about past dentists?

____

What is the most important thing to you about your dental visit today?

____

Medical History

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

☐ AIDS
☐ Allergies__________
____
☐ Anemia
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints:
Year Placed_______
☐ Asthma
☐ Blood Disease
☐ Bruise Easily
☐ Cancer
☐ Diabetes
Avg. Daily Blood Sugar
____

☐ Dizziness
☐ Epilepsy
☐ Emphysema
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Heart Conditions
☐ Heart Lesions (Congenital)
☐ Heart Murmur
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ HIV Positive

☐ High Blood Pressure
Avg Daily BP______/_____
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervous/Depression
☐ Phen Fen(1month+)
☐ Pacemaker
☐ Pregnancy
Due date:_________
☐ Radiation (head/neck)
☐ Respiratory Problems

☐ Rheumatic Fever
☐ Scarlet Fever
(No Heart Murmur)
☐ Sinus Problems
☐ Seizures
☐ Stomach Problems
Acid Reflux ☐ Y or ☐ N
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ OTHER:______________

Do you have any of the following allergies?

- ☐ Aspirin
- ☐ Nitrous Oxide
- ☐ Local Anesthetic
- ☐ Tetracycline
- ☐ Penicillin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Sulfa
- ☐ Valium
- ☐ Latex
- ☐ Other

Are you under a physician's care? Please describe.

____

____

Are you taking any medications? Please List.

____

____

Name and phone number of Family Physician

____

Consent for Services

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. If I ever have a change in my health, I will inform the office at my next dental appointment.

The undersigned hereby authorizes Orchard Family Dentistry to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Gaspard and his staff to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

I authorize Orchard Crossing Family Dentistry to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize payment from my insurance carrier to be paid directly to the dentist or dental practice and applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: ________________________________ Date: ________

Relationship to Patient:

____

Response Date: ________