

**GARGIULO & GARGIULO, D.D.S., LTD.**

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[www.chicagoperiodontal.com](http://www.chicagoperiodontal.com)

Thank you for selecting our dental healthcare team!

To help us meet 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 assist you.

**Patient Information**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

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

Birth date \_\_\_\_\_ SS# \_\_\_\_\_ Wishes to be called \_\_\_\_\_

e-mail address \_\_\_\_\_

Male  Female  Minor?  Single  Married

Employer \_\_\_\_\_ Job Title \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

In the event of an emergency, who should we contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Referred by \_\_\_\_\_

**Responsible Party/Primary Insurance**

Person responsible for account: \_\_\_\_\_ Birth date \_\_\_\_\_

Relationship to patient \_\_\_\_\_ SS# \_\_\_\_\_

E-mail address \_\_\_\_\_

Address \_\_\_\_\_

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

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Employer \_\_\_\_\_ Job Title \_\_\_\_\_

Date Employed \_\_\_\_\_ Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ Employee/Policy/Subscriber # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

**Additional Insurance**

Is patient covered by additional insurance? \_\_\_\_\_ If so, subscriber name \_\_\_\_\_

Relationship to patient \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

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

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Date Employed \_\_\_\_\_ Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ Employee/Policy/Subscriber # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

## Dental History

What would you like us to do today? \_\_\_\_\_

Are you in dental pain today? \_\_\_\_\_

Previous Dentist \_\_\_\_\_ City/State \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last dental X-Rays \_\_\_\_\_

Check off any of the following you have or have had:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Bad Breath           | <input type="checkbox"/> Food collecting between teeth  | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity to sweets   |
| <input type="checkbox"/> Bleeding Gums        | <input type="checkbox"/> Grinding or clenching teeth    | <input type="checkbox"/> Sensitivity to cold   | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Clicking/popping jaw | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to hot    | <input type="checkbox"/> Sores/growths in mouth  |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever had an adverse reaction due to a medical or dental procedure? \_\_\_\_\_

Any other information about your dental health or previous treatment? \_\_\_\_\_

## Health History

Physician's Name \_\_\_\_\_ Date of last physician visit \_\_\_\_\_

1. Are you now under the care of a physician? \_\_\_\_\_ If yes, describe \_\_\_\_\_

2. Have you ever had a blood transfusion? \_\_\_\_\_ If yes, approximate date \_\_\_\_\_

3. Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) \_\_\_\_\_

4. **Women:** Are you pregnant? If so, give due date \_\_\_\_\_ Are you nursing? \_\_\_\_\_

5. Do you smoke? \_\_\_\_\_

**Check off any of the following you have now, or have ever had:**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Sinus Problems         | <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Jaundice            |
| <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Anemia or Blood Problems        | <input type="checkbox"/> Neurological/Epilepsy | <input type="checkbox"/> Kidney Problems     |
| <input type="checkbox"/> Asthma/Hay Fever       | <input type="checkbox"/> Blood Transfusion               | <input type="checkbox"/> Cancer/Malignancies   | <input type="checkbox"/> Gout                |
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Excessive Bleeding              | <input type="checkbox"/> Tumors/Growths        | <input type="checkbox"/> Joint/Hip Replace   |
| <input type="checkbox"/> Sore/Hoarse Throat     | <input type="checkbox"/> Bruise Easily                   | <input type="checkbox"/> Chemotherapy          | <input type="checkbox"/> Arthritis           |
| <input type="checkbox"/> Emphysema              | <input type="checkbox"/> AIDS/HIV+                       | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Latex Sensitivity   |
| <input type="checkbox"/> Rheumatic Fever        | <input type="checkbox"/> Venereal Disease                | <input type="checkbox"/> Thyroid Condition     | <input type="checkbox"/> Liver Disease       |
| <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Headaches                       | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Scarlet Fever       |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Convulsions/Epilepsy            | <input type="checkbox"/> Ulcer or Colitis      | <input type="checkbox"/> Jaw Pain            |
| <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Psychiatric Treatment           | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Heart Murmur           | <input type="checkbox"/> Heart Condition (explain) _____ |  |  |

List **name** of any medication(s) you are currently taking \_\_\_\_\_

List any drug allergies you have \_\_\_\_\_

## Authorization and Release

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Patient,  
or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_