Smiles of Lombard, P.C.
845 S. Main St. Suite 201 Lombard IL 60148
Ph: 630-376-6176 Fax: 630-519-4184

Smiles of Lombard

PATIENT INFORMATION

Name _____ Birthday: _____ SS# Please provide in person or via phone. _____
Address _____ City _____State _____ Zip _____
Sex: □M □F □ Married □ Widowed □ Single □ Minor □ Separated ■ Divorced □ Partnered for ___years
Home Phone# _____ Cell Phone _____ Cell phone #2 _____
Employer _____ Work Phone# _____
Employer Address _____ City _____ State _____ Zip _____
Spouse / Partner Name _____ Employer _____ Work Phone _____
Who may we thank you for referring you? _____
Person to contact in case of emergency _____ Phone # _____

RESPONSIBLE PARTY

Name of person
Responsible for this Account: _____ Relation to Patient: _____
Address: _____ Home Phone _____
Birthday _____ Currently a patient in our office: □ Yes □ No
Employer _____ Work Phone _____
E-Mail _____ Cell Phone _____

INSURANCE INFORMATION

Name of Insured _____ Relation to patient _____
Birthday _____ SS# Please provide in person or via phone. _____
Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible _____ How much have you used _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to patient _____
Birthday _____ SS# Please provide in person or via phone. _____
Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____
Address _____ City _____ State _____ Zip _____
How much is your deductible _____ How much have you used _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____
Former Dentist _____ Date of last X-rays _____
Address _____
Check if you have or have had problems with any of the following:

□ Bad Breath □ Grinding Teeth □ Sensitivity to Hot □ Bleeding Gums
□ Loose Teeth or broken Fillings □ Sensitivity to sweets □ Sensitivity when biting □ Clicking or pooping jaw
□ Periodontal Treatment □ Sensitivity to cold □ Food collecting between teeth □ Sores or growth in your mouth

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How often do you floss? _____ Hoe often do you brush? _____

MEDICAL HISTORY

Physician Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-pen"? These include combination of Iodine, Adipex, Fastin (brand names of phentermine), Padmini (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No
Have you ever had any serious illness or operations? □ Yes □ No If yes, describe_____
Have you ever had a blood transfusion? □ Yes □ No If yes, give approximate dates _____
(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No
Check if you have or have had problems with any of the following:

☒ Anemia	■ Congenital Heart lesions	□ Hepatitis	□ Scarlet Fever
□ Arthritis, Rheumatism	□ Cortisone Treatments	□ Hernia repair	□ Shortness of Breath
□ Artificial Heart Valves	□ Cough, persistent	□ High Blood Pressure	□ Skin Rash
□ Artificial Joints, Pins, Etc.	□ Cough up blood	□ HIV / Aids	□ Stroke
□ Asthma	□ Diabetes	□ Jaw Pain	□ Swelling of Feet or Ankles
□ Back Problems	□ Epilepsy	□ Kidney Disease	□ Thyroid Problems
□ Bleeding Abnormally	□ Fainting	□ Liver Disease	□ Tobacco Habit
□ Blood Disease	□ Glaucoma	□ Mitral Valve Prolapse	□ Tonsillitis
□ Cancer	□ Headaches	□ Pacemaker	□ Tuberculosis
□ Chemical Dependency	□ Heart Murmur	□ Radiation Treatment	□ Ulcer
□ Chemotherapy	□ Heart Problems	□ Respiratory Disease	□ Venereal Disease
□ Circulatory Problems	□ Hemophilia	□ Rheumatic fever	

List medications you are currently taking:

_____
_____
_____

ALLERGIES

□ Aspirin	□ Local Anesthesia	□ Iodine	□ Other
□ Barbiturates (sleeping pill)	□ Penicillin	□ Latex	_____
□ Codeine	□ Sulfa	□ None	

To the best of mu knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor, if I or my minor child, ever have had a change in health condition.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full, at the time of the treatment, unless prior arrangements have been approved.