K&D
THE DENTAL OFFICE OF
KATZ, DOLNICK, AND ASSOCIATES
241 GOLF MILL CENTER STE.718 NILES, IL 60714
847-299-3365 KATZDOLNICK718@COMCAST.NET

NAME _____ PHONE HM_____CELL_____

ADDRESS _____CITY, STATE, ZIP _____

E-Mail Address _____ DATE OF BIRTH _____

MALE, FEMALE, SINGLE, MARRIED, WIDOWED, DIVORCED, / REFERRED BY:_____

EMPLOYER: _____ BUSINESS PHONE:_____

DENTAL INSURANCE:_____ SECONDARY DENTAL INSURANCE? YES NO_____

RESPONSIBLE PARTY:_____ SOCIAL SECURITY NO.:_____

ADDRESS:_____ PHONE:_____

PURPOSE OF VISIT:_____

HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN OR HOSPITALIZED DURING THE LAST THREE YEARS? YES NO
IF YES, EXPLAIN_____

PHYSICIAN'S NAME _____ PHONE _____

LIST ANY MEDICATIONS, DRUGS OR PILLS YOU ARE TAKING _____

_____

ALLERGIC TO? PENICILLIN / CODEINE / ASPIRIN / LOCAL ANESTHETIC / OTHER?:_____

WOMEN, ARE YOU: PREGNANT? NO / YES, __MONTHS?; NURSING? YES / NO
TAKING BIRTH CONTROL PILLS? YES / NO

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD, OR HAVE AT PRESENT. CIRCLE YES OR NO FOR EACH ITEM.

HEART DISEASE.....	YES	NO	ULCERS.....	YES	NO	CANCER OR TUMOR.....	YES	NO
CONGENITAL HEART DISEASE...	YES	NO	DIABETES.....	YES	NO	HEPATITIS.....	YES	NO
HEART MURMUR.....	YES	NO	GLAUCOMA.....	YES	NO	VENEREAL DISEASE.....	YES	NO
HIGH BLOOD PRESSURE.....	YES	NO	CONTACT LENSES.....	YES	NO	A.I.D.S.....	YES	NO
LOW BLOOD PRESSURE.....	YES	NO	EMPHYSEMA.....	YES	NO	H.I.V. POSITIVE.....	YES	NO
MITRAL VALVE PROLAPSE.....	YES	NO	CHRONIC COUGH.....	YES	NO	COLD SORES.....	YES	NO
ARTIFICIAL HEART VALVE.....	YES	NO	TUBERCULOSIS.....	YES	NO	BLOOD TRANSFUSION.....	YES	NO
HEART PACEMAKER.....	YES	NO	ASTHMA.....	YES	NO	ANEMIA.....	YES	NO
RHEUMATIC FEVER.....	YES	NO	HAY FEVER.....	YES	NO	HEMOPHILIA.....	YES	NO
ARTHRITIS.....	YES	NO	LATEX SENSITIVITY.....	YES	NO	SICKLE CELL DISEASE.....	YES	NO
CORTISONE MEDICATION.....	YES	NO	ALLERGIES..... ..	YES	NO	LIVER DISEASE.....	YES	NO
STROKE.....	YES	NO	SINUS TROUBLE.....	YES	NO	KIDNEY DISEASE.....	YES	NO
ARTIFICIAL JOINTS.....	YES	NO	RADIATION THERAPY.....	YES	NO	EPILEPSY OR SEIZURES.....	YES	NO
NEUROLOGICAL DISORDERS.....	YES	NO	CHEMOTHERAPY.....	YES	NO	PSYCHIATRIC CARE.....	YES	NO

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE? YES... NO
IF YES. EXPLAIN:_____

SIGNATURE _____ DATE _____

Emergency Contact:_____

Relationship:_____

Phone Number(s):_____

1. Do any other family members come here for their dental work? If so, who?

_____

2. How can we help you?

_____Improve the appearance of your teeth and smile

_____Overall dental health and prevention of tooth loss

_____Toothache or TMJ Pain

3. How have your dental experiences been in the past?

_____Excellent _____Fair _____Frightening/Painful

4. Have you had regular checkups and cleanings over the past several years? Yes or NO

5. When was your last cleaning?_____

6. If applicable, why have you neglected your dental health for so long?

_____Money _____Time _____Procrastination _____Pain/Fear

7. Why did you leave the dental office that treated you previously?

_____

Explain how we can improve/resolve this problem in our office, if possible.

_____

8. Have you lost any teeth?_____

If yes, has it ever been recommended to you that the tooth or teeth be replaced?_____

9. Do any of your family members wear dentures? _____

If yes, did they lose their teeth at an early age? _____

10. Do your gums ever bleed when you brush?_____

11. How often do you brush?_____

12. Which brand of tooth brush do you use? _____

13. Which brand of floss do you like to use? _____

14. Do you think that your breath is as fresh as it could be?_____

Do you use mouthwash? _____ Which brand?_____

15. Do you like your smile? _____ If no, what would you change about your smile or your teeth if you could? _____

16. What days and times are most convenient for you? Days:_____

Times:_____