SCHAUMBURG FAMILY DENTAL

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. *This confidential history will be part of your permanent records.*

OFFICE USE ONLY Account Type _____ Account ID # _____

PATIENT INFORMATION

Today's Date ____ / ____ / ____

Patient Title: (check one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

City _____ State _____ Zip Code _____

CONTACT INFORMATION

Primary Phone _____ Mobile Phone _____

Secondary Phone _____ Mobile Phone Carrier _____

Email _____ Would you like text reminders of your appointment? ☐ Yes ☐ No

Preferred contact (check one) ☐ Primary Phone ☐ Secondary Phone ☐ Mobile Phone ☐ Home Email ☐ Work Email

BILLING INFORMATION *(leave blank if same as above)*

First Name _____ Last Name _____

Address 1 _____

City _____ State _____ Zip Code _____

PRIMARY INSURANCE COVERAGE

Policy Holder Name _____ Relation to Patient _____

Policy Holder Employer _____ DOB ____ / ____ / ____ SSN ____ – ____ – ____

Insurance Co. Name _____ Group # _____

Insurance Co. Address _____ ID # _____

SECONDARY INSURANCE COVERAGE

Policy Holder Name _____ Relation to Patient _____

Policy Holder Employer _____ DOB ____ / ____ / ____ SSN ____ – ____ – ____

Insurance Co. Name _____ Group # _____

Insurance Co. Address _____ ID # _____

AUTHORIZATION

THE ABOVE SUBSCRIBER HEREBY AUTHORIZES HIS/HER INSURANCE COMPANY TO ISSUE INDEMNITY CHECKS TO THE ABOVE LISTED MEDICAL PROVIDER FOR SERVICES PROVIDED.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier OR Medicare for payment. I authorize any holder of medical or other information about me to release to insurance carriers OR the Health Care Financing Administration and its agents OR the Social Security Administration or its intermediaries OR any agency, group or person(s) necessary to secure payment any information needed for this of related Medicare claim. *For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. * The patient or his/her representative recognizing the need for health care, consents to the above listed medical provider rendering services as ordered by the physicians, including medical or surgical treatment, laboratory procedures, x-ray examinations or other services rendered under the general and specific instructions of the physicians. * I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

Patient Signature *(Parent/Guardian if minor)* _____ Date ____ / ____ / ____

CONFIDENTIAL PATIENT CASE HISTORY

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PROFILE INFORMATION

Date of Birth ____/____/____ Age _____ SSN ____—____—____

Marital Status (check one) ☐ Single ☐ Married ☐ Other

Gender (check one) ☐ Male ☐ Female ☐ Unspecified

Race (Check one)

☐ White	☐ Black/African American	☐ Hispanic	☐ American Indian/Alaskan Native
☐ Asian	☐ Asian Indian	☐ Chinese	☐ Native Hawaiian or other Pacific Island
☐ Japanese	☐ Korean	☐ Vietnamese	☐ Other _____
☐ Samoan	☐ Guamanian or Chamorro	☐ Filipino	☐ I choose not to specify

Multi-Racial (check one) ☐ Yes ☐ No ☐ Unknown

Ethnicity (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not to specify

Preferred Language (check one)

☐ English	☐ Spanish	☐ French	☐ Chinese	☐ German	☐ French Creole
☐ Tagalog	☐ Vietnamese	☐ Italian	☐ Korean	☐ Russian	☐ American Sign Language
☐ Arabic	☐ Portuguese	☐ Japanese	☐ Hindi	☐ Greek	☐ I choose not to specify
☐ Persian	☐ Urdu	☐ Gujarati	☐ Armenian	☐ Polish	

You have my permission to discuss my case with:

_____

_____

Emergency Contact:

Name _____

Phone _____

Employment Status (check one)

☐ Employed ☐ FT Student ☐ PT Student ☐ Other ☐ Retired ☐ Self Employed

Occupation _____ Employer _____

Who referred you to us?

_____

How else did you hear about us?

_____

Verification Question (Choose only one question by checking the question, then give the answer to that question)

☐ What is the name of your favorite pet?	☐ In what city were you born?	☐ What high school did you attend?
☐ What is your mother's maiden name?	☐ What is your favorite movie?	☐ On what street did you grow up?
☐ What was the make of your first car?	☐ When is your anniversary?	☐ What is your favorite color?

Verification Answer to the chosen question: _____

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CONFIDENTIAL PATIENT CASE HISTORY

REASON FOR APPOINTMENT

What symptoms are you currently experiencing? _____

_____

Are the causes known to you? If so, what are they? _____

_____

Do any positions make it feel better? ☐ Standing ☐ Walking ☐ Sitting ☐ Laying

Do any positions make it feel worse? ☐ Standing ☐ Walking ☐ Sitting ☐ Laying

Over time, this condition has: ☐ Improved ☐ worsened ☐ not changed

This condition interferes with: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other _____

Other doctors or therapists involved in treating **THIS** condition _____

List surgical procedures and years undergone:

SURGERY	YEAR	SURGERY	YEAR

SOCIAL HISTORY

Current Weight _____ Have you recently lost or gained weight? ☐ Yes ☐ No How much? _____

Mental Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Physical Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Exercise ☐ Heavy ☐ Moderate ☐ Light Hours per day _____ Type _____

Alcohol ☐ Beer ___ Glasses / Week ☐ Liquor ___ Glasses / Week ☐ Wine ___ Glasses / Week No. of Years _____

Caffeine Coffee, Tea or Soda ___ Glasses / Week No. of Years _____

Asprin No. / Day _____ No. of Years _____ Others _____

Do you smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker

If yes, how often do you smoke: ☐ Everyday smoker ☐ Occasional smoker

If yes, what is your level of interest in quitting smoking?

No Interest ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 Very interested

Schaumburg Family Dental

CONFIDENTIAL PATIENT CASE HISTORY

FAMILY HISTORY

FATHER
State of health
- ☐ Good
- ☐ Average
- ☐ Poor

- ☐ Diabetes Stroke
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Disease

Age ______ Age at death ______

Cause of Death ____________________

MOTHER
State of health
- ☐ Good
- ☐ Average
- ☐ Poor

- ☐ Diabetes Stroke
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Disease

Age ______ Age at death ______

Cause of Death ____________________

SIBLING
State of health
- ☐ Good
- ☐ Average
- ☐ Poor

- ☐ Diabetes Stroke
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Disease

Age ______ Age at death ______

Cause of Death ____________________

SIBLING
State of health
- ☐ Good
- ☐ Average
- ☐ Poor

- ☐ Diabetes Stroke
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Disease

Age ______ Age at death ______

Cause of Death ____________________

SIBLING
State of health
- ☐ Good
- ☐ Average
- ☐ Poor

- ☐ Diabetes Stroke
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Disease

Age ______ Age at death ______

Cause of Death ____________________

MATERNAL GRANDMOTHER
State of health
- ☐ Good
- ☐ Average
- ☐ Poor

- ☐ Diabetes Stroke
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Disease

Age ______ Age at death

Cause of Death ____________________

MATERNAL GRANDFATHER
State of health
- ☐ Good
- ☐ Average
- ☐ Poor

- ☐ Diabetes Stroke
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Disease

Age ______ Age at death ______

Cause of Death ____________________

PATERNAL GRANDMOTHER
State of health
- ☐ Good
- ☐ Average
- ☐ Poor

- ☐ Diabetes Stroke
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Disease

Age ______ Age at death ______

Cause of Death ____________________

PATERNAL GRANDFATHER
State of health
- ☐ Good
- ☐ Average
- ☐ Poor

- ☐ Diabetes Stroke
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Disease

Age ______ Age at death

Cause of Death ____________________

MEDICAL HISTORY

Primary Physician ______________________________ Phone ____________________

Address ______________________________ Phone # ____________________

Current medications include dosage if known

Check here if you are **NOT** current taking any medications

______________________ ______________________ ______________________

______________________ ______________________ ______________________

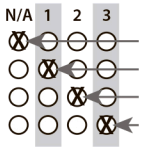
List any allergies ____

Vital Signs Office Use Only)		
Height ____________	Blood Pressure ______ / ______
Weight ____________	Pulse ____________
BMI ____________	Respiration ____________

Patient Name ____________________

SCHAUMBURG FAMILY DENTAL

SYSTEMS SURVEY - A



Instructions: Please check the appropriate circle to indicate severity

N/A: NOT APPLICABLE
1 MILD Symptoms (occurred once or twice in the last 6 months)
2 MODERATE Symptoms (occurred once or twice in the last month)
3 SEVERE Symptoms (occurred once or twice in the last week)

Section A:	N/A	1	2	3
Acid foods upset	○	○	○	○
Get chilled, often	○	○	○	○
Dry mouth, eyes,nose	○	○	○	○
Cuts heal slowly	○	○	○	○
Unable to relax, startles easily	○	○	○	○
Urine amount reduced	○	○	○	○
"Nervous" Stomach	○	○	○	○
Cold sweats often	○	○	○	○
Bladder trouble	○	○	○	○

Section B:	N/A	1	2	3
Joint Stiffness after arising	○	○	○	○
Muscle cramps at night	○	○	○	○
Eyes or Nose watery	○	○	○	○
Indigestion soon after meals	○	○	○	○
Digestion rapid	○	○	○	○
Difficulty swallowing	○	○	○	○
Constipation, diarrhea alternating	○	○	○	○
Get "chilled" infrequently	○	○	○	○
Circulation poor, sensitive to cold	○	○	○	○

Section C:	N/A	1	2	3
Eat when nervous	○	○	○	○
Get "shaky" if hungry	○	○	○	○
Heart palpates if meals missed or delayed	○	○	○	○
Afternoon headaches only	○	○	○	○
Abnormal craving for sweets or snacks	○	○	○	○

Section D:	N/A	1	2	3
Hands and feet numbness	○	○	○	○
Aware of "breathing heavily"	○	○	○	○
Swollen ankles worse at night	○	○	○	○
Muscle cramps during exercise	○	○	○	○
Shortness of breath	○	○	○	○
Chest pain	○	○	○	○
Bruise or bleed easily	○	○	○	○
Chest congestion/cough	○	○	○	○
Hypertension	○	○	○	○
Hyperventilation	○	○	○	○

Section E:	N/A	1	2	3
Dizziness	○	○	○	○
Nausea	○	○	○	○
Dry skin	○	○	○	○
Itching skin and feet	○	○	○	○
Bowel movements painful/difficult	○	○	○	○
Worrier/Insecure	○	○	○	○
Greasy Foods upset	○	○	○	○
Pain between shoulder blades	○	○	○	○
Gallbladder attacks or gallstones	○	○	○	○
Hemorrhoids	○	○	○	○
Sneezing Attacks	○	○	○	○
Bad breath	○	○	○	○

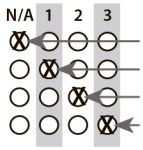
Section F:	N/A	1	2	3
Loss of taste	○	○	○	○
Pass large amounts of gas	○	○	○	○
Indigestion after eating only	○	○	○	○
Heartburn	○	○	○	○
Impotence	○	○	○	○
Abdominal pain	○	○	○	○
Gas shortly after eating	○	○	○	○
Bloating after eating	○	○	○	○

Section G:	N/A	1	2	3
Irritability	○	○	○	○
Indigestion	○	○	○	○
Poor appetite	○	○	○	○
Muscular soreness	○	○	○	○
Noise sensitivity	○	○	○	○
Weakness	○	○	○	○
Nervousness	○	○	○	○
Insomnia	○	○	○	○
Anxiety	○	○	○	○
Inability to concentrate/confusion	○	○	○	○
Frequent Stuffy nose/sinus infections	○	○	○	○
Allergy to some foods	○	○	○	○
Loose joints	○	○	○	○
Food intolerance	○	○	○	○
Poor appetite	○	○	○	○

Patient Name _____

SCHAUMBURG FAMILY DENTAL

SYSTEMS SURVEY - B



Instructions: Please check the appropriate circle to indicate severity

N/A: NOT APPLICABLE

1 MILD Symptoms (occurred once or twice in the last 6 months)

2 MODERATE Symptoms (occurred once or twice in the last month)

3 SEVERE Symptoms (occurred once or twice in the last week)

Section H:	N/A	1	2	3
Nervousness	○	○	○	○
Highly Emotional	○	○	○	○
Night Sweats	○	○	○	○
Thin, moist skin	○	○	○	○
Heart palpitates	○	○	○	○
Increased appetite without weight gain	○	○	○	○
Irritable and restless	○	○	○	○
Memory loss	○	○	○	○
Low Blood Pressure	○	○	○	○
Dizziness	○	○	○	○
Headaches	○	○	○	○
High Blood Pressure	○	○	○	○
Brown spots or bronzing skin	○	○	○	○
Muscular or nervous exhaustion	○	○	○	○

	N/A	1	2	3
Increase in weight	○	○	○	○
Decrease in appetite	○	○	○	○
Fatigue easily	○	○	○	○
Ringing in ears	○	○	○	○
Dry Skin	○	○	○	○
Constipation	○	○	○	○
Impaired hearing	○	○	○	○
Weight gain around hips or waist	○	○	○	○
Ulcers	○	○	○	○
Weakness	○	○	○	○
Chronic fatigue	○	○	○	○
Increased Perspiration	○	○	○	○
Swollen ankles	○	○	○	○

Female Only:	N/A	1	2	3
Very easily fatigued	○	○	○	○
Depressed feelings before menstruation	○	○	○	○
Painful breasts	○	○	○	○
Menstruate too frequently	○	○	○	○
Hot flashes	○	○	○	○
Acne worse at menstruation	○	○	○	○

Male Only:	N/A	1	2	3
Prostate trouble	○	○	○	○
Urination difficult	○	○	○	○
Depression	○	○	○	○
Incomplete Bowel evacuation	○	○	○	○
Migrating aches/pains	○	○	○	○

Section I:

	Y	N
Dental Problems	○	○
Blood Clots	○	○
Head Injuries	○	○
Muscle Twitching	○	○
Migraines	○	○
Gout	○	○
Diabetes	○	○
Kidney Stones/Infections	○	○
Mumps	○	○
Rheumatic Fever	○	○
Cancer/Tumors	○	○
Osteoporoses	○	○

	Y	N
Back or Neck Lumps/Masses	○	○
Leukemia	○	○
Heart Trouble	○	○
Vericose Veins	○	○
Phlebitis	○	○
Blood Disease	○	○
Stroke	○	○
Jaundice	○	○
Throat Infection/Pain/Soreness	○	○
Skin Changes/Moles	○	○
Anemia	○	○
Nodes Swollen/Painful	○	○

	Y	N
Seizures	○	○
Vertigo	○	○
Arthritis	○	○
Difficult Speech	○	○
Troubled Sleep	○	○
Hallucinations	○	○
Alcoholism	○	○
Drug Addiction	○	○
Liver Trouble	○	○
Tingling/Numbness/ Paralysis/ Weakness (in body)	○	○

Patient Name _____