



DINO MANTIS DDS
1625 N. SHERIDAN RD. WILMETTE ILLINOIS 60091
(847) 256-4776 - DRDINOMANTIS.COM

WELCOME TO OUR OFFICE

PATIENT INFORMATION:

Last name _____ First name _____ MI _____
Address _____ City _____ State _____ Zip _____
Home phone (_____) _____ - _____ Work phone (_____) _____ - _____ OK to call work Yes No
Cell phone (_____) _____ - _____ Pager (_____) _____ - _____ E-mail _____
S.S.# _____ - _____ - _____ Sex: M F Birthday _____
 Married Divorced Separated Widowed Single

RESPONSIBLE PARTY INFORMATION:

Last name _____ First name _____ MI _____
Address _____ City _____ State _____ Zip _____
Home phone (_____) _____ - _____ Work phone (_____) _____ - _____ OK to call work Yes No
Cell phone (_____) _____ - _____ Pager (_____) _____ - _____ E-mail _____
S.S.# _____ - _____ - _____ Sex: M F Birthday _____
 Married Divorced Separated Widowed Single

ADDITIONAL INFORMATION:

Phone number of the nearest relative not living with you (_____) _____ - _____
Whom do we thank for referring you? _____ Other source _____

I UNDERSTAND THAT PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. A MONTHLY CHARGE OF 1.5% PER MONTH WILL BE ADDED ON ALL ACCOUNTS NOT PAID WITHIN 30 DAYS.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and use of the same by the doctor in scientific papers or demonstrations.

Date: _____ Signature of patient/guardian _____



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MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

HAVE YOU EVER HAD THE FOLLOWING:

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. hospitalization for illness or injury..... | <input type="checkbox"/> | <input type="checkbox"/> | 25. digestive disorders..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> allergic reaction to | | | 26. arthritis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen | | | 27. glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin | | | 28. contact lenses..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin | | | 29. head or neck injuries | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> tetracycline | | | 30. epilepsy, convulsions (seizures) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> codeine | | | 31. viral infections and cold sores | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic | | | 32. any lumps or swelling in the mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride | | | 33. hives, skin rash, hay fever | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (gold, stainless steel) | | | 34. venereal disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex | | | 35. hepatitis (type _____)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> any other medications _____ | | | 36. HIV / AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems..... | <input type="checkbox"/> | <input type="checkbox"/> | 37. tumor, abnormal growth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. heart murmur..... | <input type="checkbox"/> | <input type="checkbox"/> | 38. radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. rheumatic fever..... | <input type="checkbox"/> | <input type="checkbox"/> | 39. chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. scarlet fever..... | <input type="checkbox"/> | <input type="checkbox"/> | 40. emotional problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 41. psychiatric treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. low blood pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | 42. antidepressant medication | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. a stroke..... | <input type="checkbox"/> | <input type="checkbox"/> | 43. alcohol / drug dependency..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. artificial prosthesis (i.e. heart valve or joints) | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 11. anemia or other blood disorder..... | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | |
| 12. prolonged bleeding due to a slight cut..... | <input type="checkbox"/> | <input type="checkbox"/> | 44. presently being treated for any illness | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. emphysema..... | <input type="checkbox"/> | <input type="checkbox"/> | 45. aware of a change in your general health | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. tuberculosis..... | <input type="checkbox"/> | <input type="checkbox"/> | 46. often exhausted or fatigued..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. asthma..... | <input type="checkbox"/> | <input type="checkbox"/> | 47. subject to frequent headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. sinus problems..... | <input type="checkbox"/> | <input type="checkbox"/> | 48. a heavy smoker (1 pack or more a day)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease..... | <input type="checkbox"/> | <input type="checkbox"/> | 49. considered a touchy person..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease..... | <input type="checkbox"/> | <input type="checkbox"/> | 50. often unhappy or depressed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice..... | <input type="checkbox"/> | <input type="checkbox"/> | 51. easily upset or irritated | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid or parathyroid disease..... | <input type="checkbox"/> | <input type="checkbox"/> | 52. FEMALE - taking birth control pills | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency | <input type="checkbox"/> | <input type="checkbox"/> | 53. FEMALE - pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | 54. MALE - Prostate disorders..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 24. stomach or duodenal ulcer..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

List any medications, herbal supplements, and or vitamins taken within the last two years _____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Remarks: _____

_____ Doctor's Signature _____

OVER



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DENTAL HISTORY

Referred by _____
 Previous dentist _____ How long _____
 Most recent dental exam _____ Most recent dental x-ray _____
 Most recent dental treatment _____
 How often do you have your teeth cleaned? 3 mo. _____ 4 mo. _____ 6 mo. _____ 1 year or longer _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
1. unhappy with the appearance of your teeth	<input type="checkbox"/>	<input type="checkbox"/>
2. unfavorable dental experiences	<input type="checkbox"/>	<input type="checkbox"/>
3. dental fears.....	<input type="checkbox"/>	<input type="checkbox"/>
4. problems with effectiveness or bad reactions to dental anesthetic.....	<input type="checkbox"/>	<input type="checkbox"/>
5. orthodontic treatment (braces) when	<input type="checkbox"/>	<input type="checkbox"/>
6. periodontal (gum) treatment when	<input type="checkbox"/>	<input type="checkbox"/>
7. bleeding gums.....	<input type="checkbox"/>	<input type="checkbox"/>
8. avoid brushing any part of your mouth	<input type="checkbox"/>	<input type="checkbox"/>
9. part of your mouth is sensitive to temperature.....	<input type="checkbox"/>	<input type="checkbox"/>
10. sore teeth	<input type="checkbox"/>	<input type="checkbox"/>
11. a burning sensation in your mouth	<input type="checkbox"/>	<input type="checkbox"/>
12. difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
13. an unpleasant taste or odor in your mouth	<input type="checkbox"/>	<input type="checkbox"/>
14. dry mouth, throat, and or eyes.....	<input type="checkbox"/>	<input type="checkbox"/>
15. jaw problems (temporomandibular joint).....	<input type="checkbox"/>	<input type="checkbox"/>
16. difficulty opening your mouth widely	<input type="checkbox"/>	<input type="checkbox"/>
17. stiff neck muscles	<input type="checkbox"/>	<input type="checkbox"/>
18. awaken with an awareness of your teeth or jaws.....	<input type="checkbox"/>	<input type="checkbox"/>
19. tension headaches	<input type="checkbox"/>	<input type="checkbox"/>
20. clench or grind your teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
21. jaw clicking or popping	<input type="checkbox"/>	<input type="checkbox"/>
22. lost any teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
23. do you sweat or tremble a lot during examination	<input type="checkbox"/>	<input type="checkbox"/>
24. do strange people or places make you afraid	<input type="checkbox"/>	<input type="checkbox"/>

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES NO (PLEASE CHECK YES OR NO)
 Has your present denture been relined? When _____
 Is your present denture a problem? Describe _____
 Satisfied with the appearance? _____
 Satisfied with the comfort? _____
 Satisfied with the chewing ability? _____
 When did you receive your first partial or complete denture? _____
 How long have you worn your present denture? _____

Patient's signature _____ Date _____

Doctor's Remarks: _____

_____ Doctor's Signature _____