



North Suburban Periodontics, Ltd.

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www.NorthSuburbanPeriodontics.com

Practice Limited to Periodontics and Implant Dentistry

Patient Information

Date _____ Soc. Sec. # _____ Birthdate: _____

Name _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Sex: M F Minor Single Married Divorced Widowed Separated

Employer _____

Business Address _____

Whom may we thank for referring you? _____ Driver's License # _____

In case of emergency, who should we contact? _____ Phone _____

Primary Dental Insurance

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Insured Employed By _____ Business Phone _____

Employer Address _____

Insurance Company _____ Phone _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

- Complete Other Side -

1. Are you having pain or discomfort at this time?.....YES NO
2. Have you been under the care of a medical doctor during the past two years?YES NO
- Physician's Name _____ Phone No. _____
- Address _____
3. Alcohol use: none _____, 1-2 a week _____, 3-4 a week _____, one or more a day _____
4. Are you now taking any medications including over-the-counter drugs?.....YES NO
- If yes, please list: _____
5. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?.....YES NO
- If yes, please list: _____

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Hepatitis C	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Venereal Disease	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	Smoke	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	H.I.V. Positive	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	Cold Sores/Fever Blisters	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Arteriosclerosis	YES	NO	Cosmetic Surgery	YES	NO	Hemophilia	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Psychiatric Treatment	YES	NO
Stroke	YES	NO	Hepatitis A (infectious)	YES	NO	Developmentally Disabled	YES	NO
	YES	NO	Hepatitis B (serum)	YES	NO	Cancer	YES	NO

7. Do you have or have you had any disease, condition, or problem not listed?.....YES NO
- If yes, please list: _____

For Women Only:

Are you pregnant? Yes, what month ____? No Are you nursing? Yes No Are you taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

Consent:

I hereby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough analysis. I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

I authorize the release of any medical information necessary to process my insurance claims and authorize direct payment, unless other arrangements have been made, to North Suburban Periodontics, Ltd., for all services provided by this office. I understand that I am fully and personally responsible for any and all expenses incurred by North Suburban Periodontics, Ltd., in collecting the amount guaranteed by me including but not limited to all costs and fees, including attorney fees paid to individuals, firms or agencies engaged for the purposes of collection. A monthly fee or 1.5% of the total unpaid balance, whichever is greater, will be added to accounts with unpaid principal balances over 60 days from the date of first billing.

Patient _____ Date _____

Parent or Responsible Party _____