

Dr. Lanette M. Disera D.D.S.

GENERAL DENTISTRY

4130 W. Jefferson Street • Joliet, IL 60431 • 815-744-4333 • lanettedds@sbcglobal.net

About You

Today's date: _____ SS #: _____
Patient name Last: _____ First: _____ MI: _____
What you prefer to be called: _____ Male Female Birth date: _____ Age: _____
Mailing address: _____ City: _____ State: _____ Zip: _____
Home phone #: _____ Work phone #: _____
Cell phone #: _____ Email: _____
Referred by: _____ Occupation: _____
Employer: _____ How long: _____
Employers address: _____ City: _____ State: _____ Zip: _____
Status: Minor Single Married Divorced Separated Widowed
Spouse's name: _____ Do you have children: Yes No How many: _____

Account Information Person ultimately responsible for account.

Name: _____ Relation: _____
Billing address: _____ City: _____ State: _____ Zip: _____
Drivers license #: _____ Work phone #: _____
Payment method: Cash Check Credit card _____ / _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Insurance Information

Primary dental insurance Company name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Insured's ID #: _____

Group # (Plan, Local, or Policy #): _____

Insured's name: _____ Relation: _____ Birth date: _____

Insured's employer: _____

Secondary dental insurance Company name: _____

Insured's ID #: _____ Group # (Plan, Local, or Policy #): _____

Insured's name: _____ Relation: _____ Birth date: _____

Insured's employer: _____

In Event of Emergency

Whom should we contact: _____ Relation: _____

Home phone #: _____ Work phone #: _____

Cell phone #: _____

Who is your medical doctor: _____ Phone #: _____

Health Information

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation or Chemo |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Problem |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pregnancy _____ | <input type="checkbox"/> Ulcers |

Medication Allergies: Please list.

Have you ever had any complications following dental treatment: Yes No

If yes please explain: _____

Have you been admitted to a hospital or needed emergency treatment during the past two years:

Yes No

If yes please explain: _____

Are you under the care of physician: Yes No

Name of physician: _____

Are you taking osteoporosis meds at this time: Yes No

Do you have any health problems not listed above: _____

Please list any medications or herbal supplements you are taking at this time:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change to my health, I will inform the doctors at the next appointment without fail.

Signature of patient: _____ Date: _____

How did you hear about our office? _____

A \$25 fee will be enforced for all missed appointments without a 24 hour notice.

Appointments over 1 hour in length may be assessed an additional \$25. Please initial _____