Richard P. June, D.D.S.

Proctor Professional Building
5401 N. Knoxville Avenue, Suite 302
Peoria, Illinois 61614
(309) 693-7200

Registration and Medical History

Patient Name _____

Residence Address _____

City _____ State _____ Zip Code _____

Patient Date of Birth _____ Social Security #_____

Single____ Married____ Separated____ Divorced____ Widowed____ Name of Spouse _____

Spouse Social Security # _____ Spouse Date of Birth_____

Telephone: Residence _____ Business _____

Employed By _____

Business Address _____

Spouse Employed By_____Business # _____

Whom May We Thank For Referring You? _____

Nearest Relative Not Living With You_____
(Name, Address, Telephone)

In case of emergency, who should we contact? _____

Person Responsible for Payment of account _____
(Address if different than above)

Name of Dental Insurance Company _____

Group # _____ Address _____

Dental Payment Agreement

We would like you to know our policy regarding fees. Professional services are rendered on a cash basis. Personal checks and most major credit cards will also be accepted.

If you have dental insurance, we will provide you with a claim form to file for your reimbursement. Remember that our professional services were rendered to you and not the insurance company and you are responsible for the total charges regardless of insurance involvement. All unpaid balances are assessed 1½% interest monthly. We do not accept insurance assignment.

Medical History

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. The name and address of my physician is _____
   _____
   _____
6. Have you had any serious illness or operation? ..... Yes No
   If so, what was the illness or operation? _____
7. Have you been hospitalized or had a serious illness within the past five (5) years? ..... Yes No
   If so, what was the problem? _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur and rheumatic fever ..... Yes No
   b. Congenital heart lesions ..... Yes No
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... Yes No
      1. Do you have pain in chest upon exertion? ..... Yes No
      2. Are you ever short of breath after mild exercise? ..... Yes No
      3. Do your ankles swell? ..... Yes No
      4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ..... Yes No
      5. Do you have a cardiac pacemaker? ..... Yes No
   d. Allergy ..... Yes No
   e. Sinus trouble ..... Yes No
   f. Asthma or hay fever ..... Yes No
   g. Hives or a skin rash ..... Yes No
   h. Fainting spells or seizures ..... Yes No
   i. Diabetes ..... Yes No
      1. Do you have to urinate (pass water) more than six times a day? ..... Yes No
      2. Are you thirsty much of the time? ..... Yes No
      3. Does your mouth frequently become dry? ..... Yes No
   j. Hepatitis, jaundice or liver disease ..... Yes No
   k. Arthritis ..... Yes No
   l. Inflammatory rheumatism (painful swollen joints) ..... Yes No
   m. Stomach ulcers ..... Yes No
   n. Kidney trouble ..... Yes No
   o. Tuberculosis ..... Yes No
   p. Do you have a persistent cough or cough up blood? ..... Yes No
   q. Low blood pressure ..... Yes No
   r. Venereal disease ..... Yes No
   s. Epilepsy ..... Yes No
   t. Psychiatric problems ..... Yes No
   u. Cancer ..... Yes No
   v. AIDS or other immunosuppressive disorders ..... Yes No
   w. Other _____
9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? ..... Yes No
   a. Do you bruise easily? ..... Yes No
   b. Have you ever required a blood transfusion? ..... Yes No
   If so, explain the circumstances _____
   _____
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck? Yes No
12. Are you taking any drug or medicine? ..... Yes No

13. Are you taking any of the following?
    a. Antibiotics or sulfa drugs ..... Yes No
    b. Anticoagulants (blood thinners) ..... Yes No
    c. Medicine for high blood pressure ..... Yes No
    d. Cortisone (steroids) ..... Yes No
    e. Tranquilizers ..... Yes No
    f. Antihistamines ..... Yes No
    g. Aspirin ..... Yes No
    h. Insulin, tolbutamide (Orinase) or similar drug ..... Yes No
    i. Digitalis or drugs for heart trouble ..... Yes No
    j. Nitroglycerin ..... Yes No
    k. Oral contraceptive or other hormonal therapy ..... Yes No
    l. Other _____
14. Are you allergic or have you reacted adversely to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or other antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates, sedatives, or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Other _____
15. Have you had any serious trouble associated with any previous dental treatment? _____ Yes No
    If so, explain _____
    _____
16. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
    If so, explain _____
    _____
17. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ..... Yes No
18. Are you wearing contact lenses? ..... Yes No
19. Have you had anything to eat or drink in the last 4 hours? ..... Yes No
20. Are you wearing removable dental appliances? ..... Yes No

Women

21. Are you pregnant? ..... Yes No
22. Do you have any problems associated with your menstrual period? ..... Yes No
23. Are you nursing? ..... Yes No

I hereby authorize Richard P. June, D.D.S., to obtain verbal or written medical information from my physician or family physician to aid in a more complete medical history if needed.

If we need to refer you to another dentist or specialist we will need the following authorization signed for the release of your records.

I authorize Richard P. June to release any and all information which they possess relative to my exam or examination findings, x-rays and treatment to the referring dentist or specialist or insurance carrier.

I hereby grant to Richard P. June, D.D.S., the absolute right and unrestricted permission to copyright and/or publish photographic portraits which I may be included in, in whole or in part, or composite, or distorted in character or in color or otherwise, made through any media for art advertising, trade or any other lawful purpose.

I certify that I have read and understand the above. I acknowledge that my questions, if any about the inquiries set forth above, have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. I also read the statement of policy and I understand my financial obligation.

Signature of Patient _____

Date _____

Signature of Dentist _____

Denture Patient History

It is often helpful to have some background information relevant to your experience with dentures. Please assist us by answering the following questions.

Chief dental complaint:_____
_____
_____

I have presented myself for:

- ☐ An evaluation to be fitted for my first denture.
  - ☐ At present I have teeth, but would like to have them removed.
  - ☐ All teeth have been removed prior to this visit.
- ☐ An evaluation for replacement of my existing denture.
  My present denture was made approximately _____ years ago.

  Reason you are seeking replacement at this time? _____
  _____
  _____
  _____
- ☐ Evaluation for refitting my existing denture.
- ☐ Repair of my existing denture.
  Are you pleased with …

  the fit of your existing denture? _____
  the function of your existing denture? _____
  the appearance of your denture? _____

Please use the space below to provide us with any additional information that may assist us in better serving you. Please tell us what you expect.