CRYSTAL LAKE SMILES
Dr. Parin Desai, DDS

DATE: ____/_____/_____

PATIENT REGISTRATION

Patient Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec.: _____ Gender: Male Female

E-mail address: _____

Marital Status: Married Single Divorced Separated Widowed Student Status: Full Time Part Time

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Home Phone : _____ Cellular: _____ Work Phone: _____

Name of Policy Holder: _____ Policy Holder Birth Date: _____

Policy Holder Soc. Sec.: _____ Insurance Company: _____

Employer: _____ Relationship to patient: Self Spouse Parent Other

Member ID#: _____ Group /Plan: _____

Do you have a secondary DENTAL insurance? Yes No If YES, the name of the Insurance Company is _____

PRIMARY INSURANCE

When was your last visit to a Dentist? _____ How often do you Brush? Floss? _____

What is your reason for today's visit? _____

How did you hear about us? _____

Are you interested in Whitening or Straightening your smile? _____

DENTAL HISTORY

I acknowledge that I have received a copy of Dr. Parin K. Desai's Notice of Privacy Practices and Facts About Your Coverage policy.

Patient/Guardian Signature: _____ Date: _____

CRYSTAL LAKE SMILES
Dr. Parin Desai, DDS

185-2 Heritage Dr, Crystal Lake, IL 60014
815-459-8290

Patient Medical History

PATIENT NAME _____ DATE OF BIRTH _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ....O Yes ....O No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ....O Yes ....O No If yes, please explain: _____

Have you ever had a serious head or neck injury? ....O Yes ....O No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ....O Yes ....O No If yes, please list:

Do you take, or have you taken any of a group of drugs collectively known as Fen-Phen (Common drug names Adipex, Pondimin, Ionamin, Fastin or Redux)? ....O Yes ....O No

Do you use tobacco products? ....O Yes ....O No

Do you use controlled substances? ....O Yes ....O No If yes, please list: _____

Have you ever used a bisphosphonate medication (common names Fosamax, Actonel, Didronel, Boniva, Atelvia)? ....O Yes ....O No _____ years

Women: Are you (Circle all that apply) Pregnant/Trying to get pregnant Taking Oral Contraceptives Nursing

Are you allergic to any of the following? (Circle all that apply)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

Please explain _____

Do you have, or have you had any of the following?

O AIDS/HIV Positive	O High Blood Pressure	O Stroke/Thyroid Disease	O Back Problems
O Arthritis/Gout	O Low Blood Pressure	O Epilepsy or Seizures	O Respiratory Disease
O Artificial Heart Valve	O Psychiatric Care	O Frequent Headaches	O Chronic Diarrhea
O Asthma	O Radiation Treatments	O Hepatitis	O Swollen Neck Glands
O Blood Disease	O Recent Weight Loss	O Venereal Disease	O General Allergies
O Cancer	O Rheumatic Fever	O Heart Problems	O Special Diet
O Congenital Heart Disorder	O Ulcers	O Circulatory Problems	O Yellow Jaundice
O Diabetes	O Sinus Trouble	O Nervous Problems	O Hemophilia (excessive bleeding)

Have you ever had any serious illness not listed above? O Yes O No

If yes, please explain: _____

Additional Comments:

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

Since your last visit, have there been any changes to your health that we need to be informed of? O Yes O No

If yes, please explain:

____

Date: ___________________

Since your last visit, have there been any changes to your health that we need to be informed of? O Yes O No

If yes, please explain:

____

Date: ___________________

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If yes, please explain:

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Date: ___________________

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Date: ___________________

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Date: ___________________

Since your last visit, have there been any changes to your health that we need to be informed of? O Yes O No

If yes, please explain:

____

CRYSTAL LAKE SMILES
Dr. Parin Desai, DDS

185-2 Heritage Dr.
Crystal Lake, IL 60014
815-459-8290
crystallakesmiles@gmail.com

HIPAA Consent to Leave a Message

Patient Name: _____ Date: _____

I wish to be called at: (fill all that apply)

Home: _____

Cell: _____

Other: _____

Regarding my care and follow-up.

☐ I do
☐ I do not
Give permission to leave relevant medical information on my answering machine or voice mail. These might include: treatment plans, pre-medication reminders, account information and general protected health information.

☐ I do
☐ I do not
Want relevant medical information to be shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave Protected Health Information are:

1. _____

2. _____

3. _____

_____ _____
Patient Signature Date