CLARK DENTAL CARE, LTD.
Dr. Sonia Moussa, D.D.S., P.C.
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(773) 622-4950
PLEASE PRINT

Account / Patient Information & Health History

Welcome to our office! It is our sincere hope that your visits here will be comfortable and satisfying. Please take a few minutes to complete this confidential questionnaire so that we may better serve you.

ACCOUNT INFORMATION (Primary party responsible for payment.)			
Last Name	First	Middle Initial	Dental Insurance Plan
Address			Insurance Company
City			Relationship to Patient
State	Zip		EMPLOYER INFORMATION
Phone Home ( )			Name
Cell: ( )			Address
SS#	Date of Birth		City State Zip
Marital Status ☐ S ☐ M ☐ W ☐ D	Sex ☐ M ☐ F		Phone ( ) Ext.
Email Address:			

IF YOU HAVE SECONDARY DENTAL INSURANCE OR ADDITIONAL PARTY (SPOUSE, PARENT, ETC) RESPONSIBLE FOR PAYMENT, PLEASE REQUEST 2ND FORM

PATIENT INFORMATION (Complete this section if different than above)			
Last Name	First	Middle Initial	Phone H ( ) W ( )
Address			SS# Date of Birth Marital Status ☐ S ☐ M ☐ W ☐ D
City	State	Zip	Relationship to Party Above ______ Sex ☐ M ☐ F

PATIENT HEALTH HISTORY (Please be certain to answer every question)

IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING, PLEASE CHECK "YES" OR "NO"

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	A.I.D.S.	___	___	Excessive Bleeding	___	___	Low Blood Pressure	___	___	Stroke
___	___	Alcoholism	___	___	Frequent Headaches	___	___	Malignancies	___	___	Tuberculosis
___	___	Arthritis	___	___	Heart Problems	___	___	Nervous Problems	___	___	Ulcer
___	___	Asthma	___	___	Heart Valve, Murmur	___	___	Prosthetic Joints	___	___	Venereal Disease
___	___	Chemical Dependency	___	___	Hepatitis	___	___	Psychiatric Care	___	___	Allergic/Adverse Reaction to a Drug
___	___	Circulatory Problems	___	___	Hepatitis Carrier	___	___	Radiation Treatment			
___	___	Convulsions	___	___	High Blood Pressure	___	___	Respiratory Problems			Other ______
___	___	Currently Pregnant	___	___	HIV Positive	___	___	Rheumatic Fever			______
___	___	Diabetes	___	___	Jaundice	___	___	Scarlet Fever			List Current Medications ______
___	___	Epilepsy	___	___	Latex Sensitivity	___	___	Sinus Problems			______

1. Present dental problem ______
2. How often do you visit a dentist? ______
3. When was your last visit? ______
4. What was done? ______
5. Any complication w/extractions? ______
6 Age of denture/partial ______
7 Physician's Name & Address ______
8. In Case of Emergency Notify ______ Phone ( ) ______

How Did You Learn About Us? ☐ TV ☐ News paper ☐ Friend / Relative ☐ Radio ☐ Coupon ☐ Other ______

Today's Date ______ Patients Signature ______

(Parent or Guardian if Patient is a minor)

PLEASE REMEMBER PAYMENT IS REQUIRED WHEN SERVICE IS PERFORMED. WE ACCEPT CASH, VISA, MC, AND DISCOVER CARDS FOR YOUR ADDED CONVENIENCE