TURNER AVE DENTAL CENTER
Dr Cesar Otero
GENERAL INFORMATION

Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.

All information is completely confidential.

Patients First and Last Name_____ Date of Birth_____ SS #_____

Home address_____ Apt#____ City_____ Zip **Code** _____

Home Phone_____ Cell Phone_____

Employer Name_____ Phone # _____

If the patient is a minor name of guardian_____
In case of emergency contact:
Name _____Phone #_____Relationship to Patient _____

How did you first know of our office? Who informed you of us?_____(Reflejios)(internet)(postcard

MEDICAL HISTORY

Physician:_____ Are you under a physician's care presently? N - Y Please explain:_____
Address:_____City_____Zip_____ Phone:_____
Women: Are you pregnant? Y - N Are you taking birth control pills? Y - N
Are you required to take antibiotics prior to Dental Visits? Y - N

Is there any history of: (please circle Yes Or No)

Y - N Heart disease
Y - N Blood /bleeding disorder
Y - N Emotional problem
Y - N S.T.D
Y - N Drug/alcohol use
Y - N Seizures
Y - N Psychiatric therapy
Y - N Asthma
Y - N Digestive disorder
Y - N Arthritis
Y - N Hospitalization/surgery
Y - N Artificial bones/joints
Y - N Unusual childhood disease
Y - N Cancer/Chemotherapy
Y - N Birth defect

Y - N Kidney disease
Y - N Nasal blockage
Y - N Rheumatic fever
Y - N Diabetes
Y - N Heart murmur
Y - N Hepatitis/Jaundice
Y - N Tuberculosis
Y - N High blood pressure
Y - N AIDS/HIV +
Y - N Thyroid disease
Y - N Heart surgery
Y - N Frequent colds
Y - N Artificial valves
Y - N Major illnesses

If you have answered yes to any of the above please

explain:_____
Are you taking any medications? Y - N Please list names :_____reason:_____

Do you have any allergies? Y - N what? Penicillin, Aspirin, Codeine, Erythromycin, Dental anesthetics, Food, Metals, Latex, and/ or Other:_____
Please list any other information, which you feel may be of value in the treatment._____
What is the reason for your visit today? _____
_____
Date of last Dental visit?_____ last Dental cleaning_____ Last full mouth x-rays _____
What was done at your last dental visit? _____
Previous Dentist's name _____ Telephone _____

Address _____ State _____ Zip code _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are you currently using topical fluoride? Yes_____ No _____

What other Dental aids do you use (interplak, toothpick, etc.)?_____

Do you have any Dental problems now ? Yes ____ NO_____
If yes, please describe: _____

Our office Policy

Crown, Bridges, Partials, Dentures are guarantee for 5 years
Fillings are guarantee for 36 months
Rcts are guarantee for 3 years
If the treatment fail after the time mention, we are going to re treat and new cost will applied. Initial _____

CONSENT

If insurance does not pay for any of the claims submitted, patient or the responsible party is accountable for the balance of the service's rendered. I hereby certify that I have filled out this form to the best of my knowledge and all the preceding answers are true and correct. I further, the undersigned, give full consent for performing any procedure, x-ray or exams deemed necessary for diagnosis and treatment recommended. I also authorize Turner Ave. Dental Center to run a routine credit check if needed in extending a payment plan. Patient is also responsible for $20 fee for appointment missed without giving 24 hr notice. Medicaid patients are advised that if you miss 2 or more appointments we have the right refuse to make any further appointments for you and or your child. Any payment past due 90 days will be sent to collection and have collection fees added to bill.

_____ _____
Patient/Parent/Guardian Signature Date

Dr. Otero, D.D.S

Georgetown Sq. Dental Center

(847)228-0120

TEXT MESSAGING CONSENT FORM

We are happy to provide our patients with the option to participate in our text patient communication system. You will receive a courtesy appointment reminder a day before your appointment.

☐ I consent to receiving appointment reminders via text. I understand I can withdraw my consent at any time.

☐ I Consent to receive google reviews and advertisement feedback text messages.

Text cell #: _____

Please sign below to indicate that you agree to allow us to use this information in providing our services. You may choose to discontinue your participation in our text communications system at any time just simply notify us.

Print name: _____

Signature: _____ Date: _____