

Patient Information & Health Form

Chart # (Office Use) _____

PATIENT DETAILS

Last Name	First Name	MI	Preferred Name
Title	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Family Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Child <input type="checkbox"/> Other	
Birth Date	Previous Visit	Email Address	
Home Phone	Mobile Phone	Work Phone / Ext	Best time to call:

ADDRESS

Address Line 1	Address Line 2	
City	State	Zip Code

HOW DID YOU HEAR ABOUT US?
 Dental Office Yellow Pages Internet Newspaper School Work Other _____
Referred by: (Name of person, office, or other source):**HEALTH INFORMATION & HISTORY**

If you are completing this form for another person, please provide your information here:

Advocate Name: _____ Phone: _____ Relationship: _____

EMERGENCY CONTACT (if not listed above)

Name: _____ Phone: _____ Relationship: _____

PRIMARY CARE PHYSICIAN:

Name: _____ Phone: _____ City/State: _____

Date of Last Physical Examination: _____ Date of Last Blood Test/Workup: _____

OTHER PHYSICIANS & SPECIALISTS:

Name: _____ Specialty: _____ Phone: _____ City/State: _____

Name: _____ Specialty: _____ Phone: _____ City/State: _____

SURGERY:**Within the Last 3 years have you been hospitalized or had surgery?** Yes No

If yes, please explain:

MEDICATIONS/TREATMENTS:

Have you ever been instructed to take any medications or take any special precautions before any dental appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:	

Are you taking ANY drugs, medications, or treatments currently? (If possible, please provide a complete written list of all prescribed, over-the-counter medications, vitamins & supplements)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prescribed:	
Over-the-Counter Medications (i.e. Aspirin, Advil, Allergy Medications, Sleeping Aids, Etc.):	
Vitamins, Natural or Herbal Preparations and/or Dietary Supplements:	

Are you having or ever had radiation or chemotherapy treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, dates:	For how long:	Name of Facility Performing Therapy:

Are you taking or have you ever taken or have been treated with a medication for bone density condition or metastatic cancer? (<i>Bisphosphonatus, Fosamax, Boniva, Actonel, Didronel, Skelid, Amoela, Aredia, Reclast, Xgeva, Zoledronic Acid, Denusumab</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Are you allergic to or have you ever experienced an unusual reaction to any of the following? If yes, check all that apply:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Latex	<input type="checkbox"/> Dental Anesthesia (local)	<input type="checkbox"/> Nitrous Oxide (Laughing Gas)	<input type="checkbox"/> General Anesthesia
<input type="checkbox"/> Fluoride	<input type="checkbox"/> Food/ Milk / Nut Allergy	<input type="checkbox"/> Cinnamon or Essential Oils	<input type="checkbox"/> Metals or Jewelry

Are you allergic to, or have you ever had any reaction to any of the following drugs? If yes, check all that apply:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Penicillin (or related drug)	<input type="checkbox"/> Tranquilizers (Valium)	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Codeine
<input type="checkbox"/> Aspirin / Ibuprofen (Advil, Motrin, Nuprin)	<input type="checkbox"/> Keflex (Cephalexin)	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Iodine
<input type="checkbox"/> NSAIDs (Celebrex, Naproxen, Aleve)	<input type="checkbox"/> Clindamycin (Cleocin)	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Other:

Have you had an allergic reaction or unusual response to ANY other medications, drugs, pills, treatments or applications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list:	

HEALTH CONDITIONS:

Do you have or have you ever had any of the following: (Please check Yes or No for each question)			
Congenital Heart Defects*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Allergies, Rashes, or Dermatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina or Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever or Allergies in General	<input type="checkbox"/> Yes <input type="checkbox"/> No
Atherosclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary Artery Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis, COPD, or Lung Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Surgery If yes, Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack If yes, Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problem or Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Heart Disease / Rheumatic Fever*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infective Endocarditis*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma or Any Eye Diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Other Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Valve(s) Damage / Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers or Stomach Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acid (Gastroesophageal) Reflux / GERD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia or Bleeding Disorder, or Excessive Bleeding from Any Cut or incident, or Sore or Wound that Bleeds Easily or Does Not Heal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Autoimmune or Immunocompromised Condition (ex. Lyme Disease, HIV, AIDS, Lupus, MS)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke or CVA		Active Sexually Transmitted Disease (STD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any Mental Health Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis, Jaundice, or Other Liver Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Been Treated for Any Psychiatric Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes or Blood Sugar Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	WOMEN ONLY:	
Any Artificial Joint, Joint Surgery, or Prosthesis* If yes, what joint/area: Date of Operation:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are You Pregnant? If Yes, when is Your Due Date:	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you think you might be pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Organ Transplant If yes, Organ/Body Part	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are You presently Nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any Form of Cancer or Precancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you using birth control medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use any tobacco or nicotine products (e.g., cigarettes, cigars, chew, vaping devices)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking hormone replacement therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do You Have Any Other Conditions, Diseases, or Medical Problems, or is There ANY Other Information That You Would Like Us to Know About or That We Should Be Made Aware Of?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:	

Patient Name (printed)

Date:

Patient Signature



Jon D. Nickelsen, D.D.S.

523 North McLean Boulevard

Elgin, Illinois 60123

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www.nickelsendental.com

Insurance and Financial Policy

Our office accepts all private insurance plans. We are a preferred provider for Delta Dental, United Healthcare, and Blue Cross Blue Shield. Your contract with your insurance company is between you and your insurance company. We are not a party to that contract. Ultimately, **YOU** are responsible for all charges incurred in our office.

As a courtesy to you, we will submit your dental claims to your insurance company. We will estimate your payment portion, which is due at the time services are rendered. This is only an estimate and not a guarantee of your financial obligation.

We accept cash, checks, and all credit cards. If you have a costly procedure done, we can assist you in setting up a payment plan.

Print Name

Signature

Date

Social Security Number



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HIPAA ACKNOWLEDGEMENT

I, _____, have read the **Health Insurance Portability and Accountability Act (HIPAA)**, Privacy Policy and Theft Detection and Response Procedures of Dr. Jon Nickelsen, and understand the contents. I have been instructed regarding situations that may suggest possible identity theft as described in the Identity Theft Detection and Response Policy and Procedures.

I authorize the office of Dr. Jon Nickelsen to disclose protected health information to other health and dental providers to assist them in providing treatment to me.

Print Name

Signature

Date



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APPOINTMENT POLICY

Effective: March 1st, 2026

At Nickelsen Family Dentistry, appointments are made in advance by reserving the doctor's and Hygienist's time to accommodate you and the treatment to be performed.

Additionally, our staff spends time meticulously preparing for each appointment by sterilizing, organizing, and arranging the appropriate instruments and materials prior to your arrival. This ensures the highest standard of dentistry for which we pride ourselves.

We therefore require no less than 48-hour notice prior to canceling or rescheduling appointments. Patients that cancel or reschedule their appointments without prior notice will be assessed a \$50.00 per hour charge to offset lost time, effort and materials that the staff has spent preparing for your appointment.

We look forward to accomplishing all your treatment needs in a comfortable and caring environment. Thank you in advance for your cooperation.

Print Name

Signature

Date

Cell Phone #

Email Address: