Jon D. Nickelsen, D.D.S.
523 North McLean Boulevard Elgin, Illinois 60123 Phone 847-742-8811 - Fax 847-742-8818 info@nickelsendental.com

Patient Information & Health Form

Chart # (Office Use)_____

PATIENT DETAILS

Last Name	**First Name**	**MI**	**Preferred Name**
Title	**Gender:** ☐ Male ☐ Female	**Family Status:** ☐ Married ☐ Single ☐ Child ☐ 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

APPOINTMENT PREFERENCES

Preferred Days: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat
Preferred Time: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time

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:

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SURGERY:

Within the Last 3 years have you been h 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?	☐ **Yes** ☐ **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)	☐ **Yes** ☐ **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?			☐ **Yes** ☐ **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? *(Bisphonphonatus, Fosamax, Boniva, Actonel, Didronel, Skelid, Amoela, Aredia, Reclast, Xgeva, Zoledronic Acid, Denusumab)*	☐ **Yes** ☐ **No**

Are you allergic to or have you ever experienced an unusual reaction to any of the following? If yes, check all that apply:			☐ **Yes** ☐ **No**
☐ Latex	☐ Dental Anesthesia (local)	☐ Nitrous Oxide (Laughing Gas)	☐ General Anesthesia
☐ Fluoride	☐ Food/ Milk / Nut Allergy	☐ Cinnamon or Essential Oils	☐ 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:			☐ **Yes** ☐ **No**
☐ Penicillin (or related drug)	☐ Tranquilizers (Vallum)	☐ Tetracycline	☐ Codeine
☐ Aspirin / Ibuprofen (Advil, Motrin, Nuprin)	☐ Keflex (Cephalexin)	☐ Sulfa Drugs	☐ Iodine
☐NSAIDs (Celebrex, Naproxen, Aleve)	☐ Clindamycin (Cleocin)	☐Erythromycin	☐ Other:

Have you had an allergic reaction or unusual response to ANY other medications, drugs, pills, treatments or applications?	☐ **Yes** ☐ **No**
If yes, please list:	

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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*	☐ Yes ☐ No	Skin Allergies, Rashes, or Dermatitis	☐ Yes ☐ No
Angina or Chest Pains	☐ Yes ☐ No	Hay Fever or Allergies in General	☐ Yes ☐ No
Atherosclerosis	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Congestive Heart Failure	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Coronary Artery Disease	☐ Yes ☐ No	Tuberculosis, COPD, or Lung Disorder	☐ Yes ☐ No
Heart Surgery If yes, Date:_____	☐ Yes ☐ No	Skin Problems	☐ Yes ☐ No
Heart Attack If yes, Date:_____	☐ Yes ☐ No	Sore or Wound that Bleeds Easily or Does Not Heal	☐ Yes ☐ No
Rheumatic Heart Disease / Rheumatic Fever*	☐ Yes ☐ No	Thyroid Problem or Disease	☐ Yes ☐ No
Infective Endocarditis*	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Glaucoma or Any Eye Diseases	☐ Yes ☐ No
Heart Valve(s) Damage / Mitral Valve Prolapse	☐ Yes ☐ No	Epilepsy or Other Seizure Disorder	☐ Yes ☐ No
Artificial Heart Valve*	☐ Yes ☐ No	Any Kidney Problems	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Ulcers or Stomach Problems	☐ Yes ☐ No
Stroke or CVA	☐ Yes ☐ No	Acid (Gastroesophageal) Reflux / GERD	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Autoimmune or Immunocompromised Condition (ex. Lyme Disease, HIV, AIDS, Lupus, MS)	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Active Sexually Transmitted Disease (STD)	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Any Mental Health Issues	☐ Yes ☐ No
Hemophilia or Bleeding Disorder	☐ Yes ☐ No	Been Treated for Any Psychiatric Condition	☐ Yes ☐ No
Excessive Bleeding from Any Cut or incident	☐ Yes ☐ No	WOMEN ONLY:	
Any Artificial Joint, Joint Surgery, or Prosthesis* If yes, what joint/area: _____ Date of Operation: _____ _	☐ Yes ☐ No	Are You Pregnant? If Yes, when is Your Due Date:	☐ Yes ☐ No
Diabetes or Blood Sugar Problems	☐ Yes ☐ No	Do You Think You Might Be Pregnant?	☐ Yes ☐ No
Hepatitis, Jaundice, or Other Liver Problems	☐ Yes ☐ No	Are You Presently Nursing?	☐ Yes ☐ No
Any Form of Cancer or Precancer	☐ Yes ☐ No	Are You Using Birth Control Medication?	☐ Yes ☐ No
Organ Transplant If yes, Organ/Body Part_____	☐ Yes ☐ No	Are You Taking Hormone Replacement Therapy?	☐ Yes ☐ 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?	☐ Yes ☐ No
If yes, please explain:	

Patient Name (printed) Date:

Patient Signature

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Insurance and Financial Policy

Our office accepts all private insurance plans. We are a preferred provider for Delta Dental and United Healthcare. 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: