

# Chicago Dental Society Foundation Clinic

416 E. Roosevelt Road  
Wheaton IL 60187

## Volunteer Data Form

Name: \_\_\_\_\_ Birth Day: Month: \_\_\_\_ Day: \_\_\_\_

Title: DDS \_\_\_\_ DMD \_\_\_\_ RDH \_\_\_\_ Dental Assistant \_\_\_\_ Do you mind being in office Photos? YES NO

Office Address: \_\_\_\_\_ Place (X) next to contact address and phone

Cell. #: \_\_\_\_\_

Office Phone #: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Home Address: \_\_\_\_\_

Due to our patient population and potential exposure to TB,

Date of last TB test: \_\_\_\_\_ Pos. \_\_\_\_ Neg. \_\_\_\_

Date of last Hepatitis vaccine series or booster: \_\_\_\_\_

IL Prof. License # (attach copy) \_\_\_\_\_ IL DEA #: \_\_\_\_\_

Length of appointment time you prefer: \_\_\_\_\_

Day or Days of the week you are available: Mon. \_\_\_\_ AM / PM Tues. \_\_\_\_ AM / PM Wed. \_\_\_\_ AM / PM  
Thurs. \_\_\_\_ AM / PM Fri. \_\_\_\_ AM / PM

AM-9:00 to 12:00 / PM-1:00 to 4:00 / All day- 9:00 to 4:00 Other you would prefer: \_\_\_\_\_

Does your schedule allow you to fill in on short notice? YES NO

Side of chair you work on: Right side \_\_\_\_ Left side \_\_\_\_ Glove Size: \_\_\_\_\_

Disposable gown size: Small \_\_\_\_ Mediums \_\_\_\_ Large \_\_\_\_ Extra Large \_\_\_\_

Disposable Mask type: Cone \_\_\_\_ Ear loop \_\_\_\_ Tie \_\_\_\_ Face shield \_\_\_\_

Do you treat children in your office? YES \_\_\_\_ NO \_\_\_\_ / will you treat children at our clinic? YES \_\_\_\_ NO \_\_\_\_

Doctors: Do you perform basic/ nonsurgical extractions in your office? YES \_\_\_\_ NO \_\_\_\_

Dental Procedures Preferred: \_\_\_\_\_

Any additional amenities you would like us to have for you: \_\_\_\_\_

Signed: \_\_\_\_\_

Dated: / /