Patient Information

Date _____

Name _____ Date of Birth _____

Preferred Name _____Social Security Number_____

Mailing Address _____

_____

Home Phone _____ Cell Phone _____

Work Phone _____ *Preferred contact method*_____

Email Address _____

Marital Status _____ Gender _____

Employer _____ Occupation _____

Spouse's Name_____ Spouse's DOB_____

Insurance Information

Primary: _____

ID# _____ Group # _____

Name of Insured*:* _____

DOB of Insured: _____

Relationship to Insured: _____

Secondary: _____

ID# _____Group # _____

Name of Insured*:* _____

DOB of Insured: _____

Relationship to Insured: _____

I will answer all health questions to the best of my knowledge. _____

Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize, *by my verbal consent*, the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

_____ _____

Signature of Patient or Guardian **Date**

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.

As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

_____ _____

Signature of Patient or Guardian **Date**

DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.)

_____

Previous Dentist: _____

Last Visit: _____Date of last cleaning: _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

_____

Are you nervous about seeing a dentist? ❑ Yes! ❑ No If yes, please tell us why:

_____

How often do you brush? _____

Do you floss? ❑ Yes ❑ No How often? _____

Please check if it applies:

☐ I clench or grind my teeth during the day or while sleeping.

☐ My gums feel tender or swollen

☐ My gums bleed while brushing or flossing.

☐ I get canker sores or cold sores.

☐ I have problems eating or sensitivity.

☐ I like my smile.

☐ I have had orthodontics.

☐ I prefer tooth-colored fillings.

☐ I have had a facial or jaw injury.

☐ My jaw clicks or pops.

☐ I avoid brushing part of my mouth due to pain.

☐ I want my teeth straight.

☐ I want my teeth whiter.

☐ I feel like have dry mouth.

☐ I wear a full or partial denture.

☐ I have had teeth replaced with dental implants.

What are your dental priorities? *(e.g.: apprentice, dental health, financial considerations, etc.)*

_____

Who selected this office (circle one): *Self spouse parent employer*

Who can we thank for referring you? _____

Where did you find our contact info? *Referral Insurance Plan Online*
Other: _____

PATIENT'S MEDICAL HISTORY

I consider my health to be *(please check one)* ❑ Excellent ❑ Good ❑ Fair ❑ Poor
Please check the box if you currently have or have history of any of the following:

☐AIDS/HIV Positive
☐Anemia
☐Arthritis
☐Anxiety
☐Artificial Heart Valve(s)
☐Artificial Joint(s)
☐Asthma
☐Back Problems
☐Blood Disease
☐Cancer
☐Chemo/radiation therapy
☐Circulation Problems
☐Cortisone Treatments
☐Cough, persistent or bloody
☐Depression
☐Diabetes
☐Emphysema
☐Epilepsy
☐Excessive Thirst or Urination
☐Fainting
☐Food allergies
☐Glaucoma
☐Hay Fever
☐Headaches, frequent/severe
☐Hearing Loss
☐Heart Murmur
☐Heart problems, other
☐Hemophilia
☐Herpes
☐Hepatitis, Type:
☐High Blood Pressure
☐History of Drug Addiction
☐Infectious Mononucleosis (mono)
☐Jaundice
☐Jaw pain
☐Kidney disease
☐Liver disease
☐Low Blood Pressure
☐Mitral Valve Prolapse
☐Nervous system problems
☐Pacemaker
☐Psychiatric care
☐Respiratory Disease
☐Rheumatic Fever
☐Seizure Disorders
☐Sexually Transmitted Disease:
☐Shingles
☐Shortness of Breath
☐Sinus Problems
☐Skin Rash
☐Stroke
☐Surgical Implants
☐Swelling, feet or ankles
☐Thyroid Problems
☐Tuberculosis
☐Ulcers/colitis/acid reflux
☐Vision Impairment

☐I usually take an antibiotic prior to dental treatment.
☐Have you ever taken Fen-Phen or Redux?
☐ I have consumed alcohol within the last 24 hours.
☐ I smoke or use tobacco. If yes, how much per day? How many years?

☐I have had major surgery. Year, Type of operation: _____

_____

☐Do you have any other medical problem or medical history NOT listed on this form?

_____

WOMEN

☐Are you taking birth control medication?

☐Are you or could you be pregnant or nursing?

Are you allergic to any of the following?

☐ Aspirin
☐ Ibuprofen
☐ Sulfa Drugs/Sulfites/Sulfides
☐ Penicillin
☐ Codeine
☐ Latex, Metals, Plastics
☐ Local Anesthetics (Novocain)
☐ Other Medications - Which ones? -

_____

Doctor's Notes Only:

Please list all medications you are currently taking (or provide list):

Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Physician's Name _____ Phone _____
Address _____Fax _____

In the event of an emergency please contact:
Name _____Relationship_____ Phone_____

Initial medical/dental health reviewed by:

X _____ _____ X _____ _____
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X _____ _____ X _____ _____
Doctor's Signature Date Patient's/Guardian Signature Date

Lake Street Family Dental, PA- 119 Lake St. S., Ste 1., Mora, MN 55051

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____ have been informed of this office's Notice of Privacy Practices.

_____

Print Name

_____

Signature

_____

Date

Name(s) of person(s) who may access patient information:

_____

For Office Use Only

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other: _____