Welcome!

The following confidential information is important for the dentist to know in planning your dental care.
Please answer each question as completely as possible. Thank you.

Patient Information

Name _____ Birthdate _____ SS # _____

How would you like to be addressed? _____ Email _____

Address _____ City _____ St. _____ Zip _____

Home Phone (___) _____ Work Phone (___) _____ ext _____ Cell Phone _____

Employer _____ Occupation _____

Check Appropriate Box: ___ male ___ female ___ single ___ married ___ other

Spouse's name _____ Birthdate _____

Employer _____ Work Phone _____

Whom may we thank for referring you to our office? _____

Person to contact in case of emergency _____ **Phone** _____

Emergency contact's relationship to patient _____

Account Information **(Please present your insurance card or claim form at your visit.)**

Primary Dental Insurance _____ Group # _____

Name of Policyholder _____ Social Security # _____

Secondary Dental Insurance _____ Group # _____

Name of Policyholder _____ Social Security # _____

The information I have provided to Cherrywood Dental Care is correct to the best of my knowledge.

I give my consent to Cherrywood Dental Care to discuss with my spouse, family members, or guardian information to facilitate my treatment and/or payment on my account.

I hereby authorize Cherrywood Dental Care to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-determination of treatment plan fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Cherrywood Dental Care for the services rendered to me by either the doctor or the staff. I understand that I am ultimately responsible for the total cost of my services.

I understand 48 business hours notice is needed when cancelling or rescheduling an appointment. Failure to do so may result in a $50.00 cancellation fee.

I agree to be responsible for payment of all services rendered on my or my dependant's behalf, and I understand finance charges may be added to remaining balances over sixty (60) days. I am aware that there will be an additional charge of 40% of my bill in the event my account is turned over to a collection agency and the Credit Bureau of Minneapolis/St. Paul.

I have received a copy of this office's Notice of Privacy Practices.

Signature of Patient/Guardian _____ Date _____

Medical Information

Physician name & location ______________________________ phone __________

Are you presently under a physician's care? yes no Explain ______________________

Have you ever had a serious illness or accident? yes no Explain ______________________

List any over-the-counter, herbal, or prescription medications/drugs & dosages that you are taking. __________

____

Are you allergic to: Penicillin Erythromycin Sulfa Latex Other ______________________

Do any of the following apply to you now or in the past?

Abnorm blood pressure	yes	no	Congenital heart defect	yes	no	Nervousness	yes	no
Abnormal bleeding	yes	no	Diabetes	yes	no	Pacemaker	yes	no
AIDS/HIV positive	yes	no	Epilepsy/seizures	yes	no	Pregnant	yes	no
Anemia	yes	no	Excessive thirst	yes	no	Prosthetic implant	yes	no
Arthritis	yes	no	Excessive urination	yes	no	Radiation therapy	yes	no
Artificial joint	yes	no	Glaucoma	yes	no	Sinus trouble	yes	no
Asthma/hay fever	yes	no	Headaches	yes	no	Stroke	yes	no
Cancer	yes	no	Heart disease	yes	no	Thyroid problem	yes	no
Chemical dependency	yes	no	Hepatitis	yes	no	Tuberculosis	yes	no
Chemo Therapy	yes	no	Jaundice	yes	no	Tumors	yes	no
Circulatory problems	yes	no	Kidney problems	yes	no	Ulcers	yes	no
Cold sores	yes	no	Mental health care	yes	no	Other__________		

Have you ever been advised to be premedicated prior to dental treatment for any of the above? yes no

Signature of Patient/Guardian ______________________________ Date ______________

Signature of Dentist ______________________________ Date ______________

Date:__________ ☐ No Medical Changes ☐ See Progress Notes Pt. Int.__________ Dr. __________	Date:__________ ☐ No Medical Changes ☐ See Progress Notes Pt. Int.__________ Dr. __________	Date:__________ ☐ No Medical Changes ☐ See Progress Notes Pt. Int.__________ Dr. __________
Date:__________ ☐ No Medical Changes ☐ See Progress Notes Pt. Int.__________ Dr. __________	Date:__________ ☐ No Medical Changes ☐ See Progress Notes Pt. Int.__________ Dr. __________	Date:__________ ☐ No Medical Changes ☐ See Progress Notes Pt. Int.__________ Dr. __________
Date:__________ ☐ No Medical Changes ☐ See Progress Notes Pt. Int.__________ Dr. __________	Date:__________ ☐ No Medical Changes ☐ See Progress Notes Pt. Int.__________ Dr. __________	Date:__________ ☐ No Medical Changes ☐ See Progress Notes Pt. Int.__________ Dr. __________
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