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 (Minor)

Name_____ Birthdate_____

Address_____ City_____ St._____ Zip_____

Home Phone _____ ___ Male ___ Female

Parent's Name_____ Birthdate _____

Employer _____ Work Phone_____ ext. _____

Parent's Name_____ Birthdate _____

Employer_____ Work Phone_____ ext. _____

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

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

Account Information

Person responsible for this account _____ Social Security # _____

Primary Dental Insurance _____ Group # _____

Name of Policyholder_____ Social Security # _____

Secondary Dental Insurance _____ Group # _____

Name of Policy Holder _____ Social Security # _____

(Please present card or claim form to receptionist.)

Dental Information

Reason for this visit _____ When was your last dental visit? _____

Name of previous dentist _____ Reason for leaving? _____

Have you had a complete series of dental x-rays taken? When? Where? _____

Are you having a problem with any of the following?

Dental decay	yes	no	Loose teeth	yes	no	Grind/clench teeth	yes	no
Toothache	yes	no	Bad breath	yes	no	Jaw joint noise	yes	no
Tooth removed	yes	no	Food collects	yes	no	Locked jaw	yes	no
Temp. sens.	yes	no	Tooth injury	yes	no	Improper bite	yes	no
Pressure sens.	yes	no	Mouth sores	yes	no	Crowded teeth	yes	no
Sweet sens.	yes	no	Swelling	yes	no	Unpleasant taste	yes	no
Sore gums	yes	no	Other_____					

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 medications/drugs & dosages that you are taking. _____

Are you allergic to: Penicillin Erythromycin Local Anesthetic Latex Other _____

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

Heart disease	yes	no	Hepatitis	yes	no	Jaundice	yes	no
Circulatory problems	yes	no	Arthritis	yes	no	Nervousness	yes	no
Congenital heart defect	yes	no	Mental health care	yes	no	Venereal disease	yes	no
Abnorm blood pressure	yes	no	Cold sores	yes	no	Radiation therapy	yes	no
Diabetes	yes	no	Anemia	yes	no	Sinus trouble	yes	no
Epilepsy/seizures	yes	no	Excessive thirst	yes	no	Thyroid problem	yes	no
AIDS/HIV positive	yes	no	Excessive urination	yes	no	Kidney problems	yes	no
Abnormal bleeding	yes	no	Back problems	yes	no	Asthma/hay fever	yes	no
Blood transfusion	yes	no	Chemical dependency	yes	no	Tumors	yes	no
Stroke	yes	no	Fainting spells	yes	no	Ulcers	yes	no
Prosthetic implant	yes	no	Glaucoma	yes	no	Pregnant	yes	no
Tuberculosis	yes	no	Headaches	yes	no	Other_____		

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

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

The above information is correct to the best of my knowledge. I authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. I authorize payment of medical/dental benefits to undersigned dentist for services prescribed/performed. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, and I understand finance charges may be added to remaining balances over sixty (60) days. I am aware that in the event my account is turned over to a collection agency and the Credit Bureau of Minneapolis/St. Paul that there will be an additional charge of 40% of my bill.

Signature of Patient/Guardian _____ Date _____

Signature of Dentist _____ Date _____