Northern Lakes Dental

Patient Information

Patient Name: _____ _____
First MI Last (Preferred Name)

Gender: ☐ Male ☐ Female Family Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Social Security #: _____ Birth Date: _____ E-mail address: _____

Phone (Home): _____ (Cell): _____ (Work): _____

☐ I would like to receive correspondence via text messages

Address: _____
Mailing Address City State Zip Code

Spouse: _____ Work Phone: _____

In Case of Emergency Name: _____ Phone: _____

Responsible Party

Name: _____ _____
First MI Last (Preferred Name)

Gender: ☐ Male ☐ Female Relationship to Patient: _____

Social Security #: _____ Birth Date: _____ E-mail address: _____

Phone (Home): _____ (Cell): _____ (Work): _____

☐ I would like to receive correspondence via text messages

Address: _____
Mailing Address City State Zip Code

Spouse: _____ Work Phone: _____

In Case of Emergency Name: _____ Phone: _____

Dental Insurance Information

Primary

Subscriber: _____ Is subscriber a patient at this office? ☐ Yes ☐ No
First MI Last

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____ Phone: _____
Mailing Address City State Zip Code

Subscriber's Employer: _____ Phone: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name, Address and Phone: _____

Secondary

Subscriber: _____ Is subscriber a patient at this office? ☐ Yes ☐ No
First MI Last

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____ Phone: _____
Mailing Address City State Zip Code

Subscriber's Employer: _____ Phone: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name, Address and Phone: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Dental Office

☐ Online _____ ☐ Other _____

Name of person or office referring you to our practice: _____

Dental History

Have you ever had any of the following? Please check those that apply:

☐ Periodontal treatment ☐ Clicking or popping jaw ☐ Sores or growths in your mouth

Are you happy with the appearance of your teeth?: ☐ Yes ☐ No If No, please explain: _____

Reason for this visit: _____ Date of Last Dental Visit: _____

Former Dentist: _____ Date of Last Dental X-ray: _____

Health Information

Although Dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health Problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If Yes, please explain: _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No
Are you taking any medications, pills or drugs? ☐ Yes ☐ No Please list: _____
Have you ever taken Fosomax, Boniva, Actonel or any other medications containing Bisphosporates? ☐ Yes ☐ No Please list: _____
Special Diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances?

Women: Are you pregnant? ☐ Yes ☐ No Taking Oral Contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other

If Yes, please explain: _____

Do you have, or have you had any of the following:

AIDS/HIV Positive	☐ Yes ☐ No	**Epilepsy or Seizures**	☐ Yes ☐ No	**Irregular Heartbeat**	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	**Excessive Bleeding**	☐ Yes ☐ No	**Kidney Problems**	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	**Excessive Thirst**	☐ Yes ☐ No	**Liver Disease**	☐ Yes ☐ No
Angina	☐ Yes ☐ No	**Frequent Headaches**	☐ Yes ☐ No	**Lung Disease**	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	**Hay Fever**	☐ Yes ☐ No	**Osteoporosis**	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	**Heart Attack**	☐ Yes ☐ No	**Pain in Jaw Joints**	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	**Heart Disease**	☐ Yes ☐ No	**Psychiatric Care**	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	**Heart Murmur**	☐ Yes ☐ No	**Radiation Treatments**	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	**Heart Pace Maker**	☐ Yes ☐ No	**Renal Dialysis**	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	**Hemophilia**	☐ Yes ☐ No	**Sinus Trouble**	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	**Hepatitis A**	☐ Yes ☐ No	**Stroke**	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	**Hepatitis B or C**	☐ Yes ☐ No	**Thyroid Disease**	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	**Herpes**	☐ Yes ☐ No	**Tumors or Growth**	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	**High Blood Pressure**	☐ Yes ☐ No	**Ulcers**	☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

I understand all professional services rendered are charged directly to the patient and that the patients are personally responsible for payment of fees. Payment is due when services are rendered unless other arrangements have been made. If dental insurance I hereby authorize payment of the dental benefits directly to the dental provider and agree to be responsible for payment for services which are not paid by my dental benefit plan. I also authorize release of information relating to insurance claims and authorize the use of my signature on all insurance submissions.

_____ Date: _____
Signature of patient or guardian

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