Welcome to our office! Please tell us about yourself.

Name: ____
last first middle initial

Preferred Name: ____________________ (please circle one) Male Female

Address: ____________________ City: __________ State: ______ Zip: ______

Date of Birth: ______________ Social Security # ____________________

Marital Status: (please circle one) Single Married Divorced Widowed Separated Domestic Partner

Home Phone: ____________________ Work Phone: ____________________

Cell Phone: ____________________ Email Address: ____________________

I prefer to be contacted on my: (please circle one) home phone work phone cell phone email

Employer: ____

Whom may we thank for referring you or how did you hear about our office? ____________________

Person to contact in case of emergency: ____________________ Phone: ______________

Insurance - Primary *

Subscriber Name: ______________ Relationship to Patient: ______ Subscriber DOB: ______

Subscriber SSN/ID: ______________ Subscriber Employer: ____________________

Insurance Company Name: ____

Insurance Company Address: ____

Insurance Company Phone: ____________________ Group Number: ______________

Insurance - Secondary *

Subscriber Name: ______________ Relationship to Patient: ______ Subscriber DOB: ______

Subscriber SSN/ID: ______________ Subscriber Employer: ____________________

Insurance Company Name: ____

Insurance Company Address: ____

Insurance Company Phone: ____________________ Group Number: ______________

* *

Medical History

Are you under physician's care now? Yes No ____________________

Have you ever been hospitalized or had a major operation? Yes No ____________________

Have you ever had a serious head or neck injury? Yes No ____________________

Are you taking any medications, pills, or drugs? Yes No ____________________

Do you take, or have you taken, Phen-Fen or Redux? Yes No ____________________

Have you ever taken Fosamax, Boniva, Actonel or
any other medications containing bisphosphonates? Yes No ____________________

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you... Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following? (please circle)

Aspirin Penicillin Codeine Acrylic
Metal Latex Sulfa Drugs Local Anesthetics
Other? Yes No ____________________

Do you use controlled substances? Yes No ____________________

Do you have, or have you had, any of the following? (please circle)

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Breathing Problems	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tumors or Growths
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Ulcers
Convulsions	Heart Trouble/Disease	Psychiatric Care	Venereal Disease
			Yellow Jaundice

CHANHASSEN FAMILY DENTISTRY, P.A.

Have you ever had any serious illness not listed? Yes No ____________________

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.

Signature ____________________ Date ____________________

Doctor Signature ____________________ Date ____________________

* Dental History

How may we help you today? ______________________________

Your current dental health is: (please circle one) Good Fair Poor

Are you currently in pain? Yes No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) Yes No

Do you like your smile? Yes No

Are you happy with the color of your teeth? Yes No

Do you gums bleed? Yes No

How many times do you: floss/week? __________ brush/day? __________

Are your teeth sensitive to heat, cold or anything else? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

Have you ever had any unfavorable dental experiences? Yes No

CHANHASSEN FAMILY DENTISTRY, P.A.

When was your last dental cleaning? ______________________________

When was your last dental visit? ______________________________

Why did you leave your previous dentist? ______________________________

How can we accommodate you better during your dental visit? ______________________________

____

* HIPPA Privacy Practices

The Notice of Privacy Practices covers services provided to you by our office. We are required by law to maintain the privacy of protected health information and to provide you with the notice of our legal duties and privacy practices with respect to protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

The full document is available to you if you would like to review it.

I acknowledge I have reviewed Chanhassen Family Dentistry's health information privacy and security policies and procedures.

Signature: ______________________________ Date: __________

8116 Mallory Court
Chanhassen, MN 55317
952-443-3368

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care, though it may not be included in my insurance contract.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment for the purpose of evaluating and administrating claims for insurance benefits or to another dentist or physician as may be medically necessary.

I hereby authorize payment of the insurance benefits directly to Chanhassen Family Dentistry, P.A., otherwise payable to me.

I understand that my dental insurance carrier or payor of my dental benefits may be less than the actual bill for services. I understand I am financially responsible for payment(s) in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I understand that my portion of the bill is due at the time services are rendered whether or not I carry dental insurance. I also understand that balances over 30 days are subject to finance charges as indicated on my statement. Balances over 90 days will be sent to another company to collect.

I understand that there will be a thirty-five percent collection fee added to any account turned over to another company to collect due to non-payment to Chanhassen Family Dentistry, P.A.

I understand that there will be a $30 service charge added to any returned payments.

I understand that there may be a fee for cancelled or failed appointments without 24 hours notice.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: ______________________________________ Date: ______________________