Patient Registration / Child

WELCOME! Our goal is to help you have the healthiest, brightest smile possible. Please provide the following information as completely as you can. The better we communicate, the better we can care for your dental needs.

Patient Name First MI Last	Nickname (if any)	Date of Birth	
Address	City	State	Zip
Cell # (of parent)	Hobbies/Pets/Interests		
Home Phone #			
Email:	School Grade	Gender ☐M ☐F	

Preferred method of confirmation: ☐email/text ☐phone call only ☐email only ☐text only

Account Information

Father's Full Name	Position	Work Phone #
Father's Employer		
Mother's Full Name	Position	Work Phone #
Mother's Employer		
Person responsible for account (address, if different from above)		

Insurance

Primary Dental Insurance Company _____

Name of Policyholder _____ Group # _____

Primary Policyholders birth date _____ Member ID # _____

Policyholder's employer (if not above) _____

Relationship to Policyholder _____

Address of Policyholder _____

Secondary Dental Insurance Company _____

Name of Policyholder _____ Group # _____

Secondary Policyholders birth date _____ Member ID # _____

Policyholder's employer (if not above) _____

Relationship to Policyholder _____

Address of Policyholder _____

Emergency contact (name and phone #):

Name Phone #

Other family members in this practice:

How did you learn about our dental office?
If from a friend or relative, his/her name:

I authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. If additional information is needed, I authorize this office to contact the appropriate health care provider or agency to obtain such information. I understand that dental insurance is a contract between the policyholder and the insurance carrier, and that I am responsible for payment of fees for services not covered in part or in whole by the insurance carrier. I authorize payment of dental insurance benefits directly to this office. The above information is correct to the best of my knowledge. Charges may be assessed if less than 48 hours notice or no notice is given when an appointment cannot be kept. If I choose to print my name on forms, I accept this as my signature.

Patient Signature _____ Date _____

POS Reorder # 0217911

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MEDICAL HISTORY

PATIENT NAME_____ Date of Birth _____

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.

Emergency Contact: Name _____ Phone_____
Name of Primary Care Physician _____ Clinic Location _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain:_____
Have you ever needed to take antibiotics prior to dental treatment? ◯ Yes ◯ No If yes, please explain:_____
Have you ever taken Fosamax, Boniva, Actonel or any other bone-densifying drugs (oral or IV)? ◯ Yes ◯ No _____
Do you smoke or use other forms of tobacco? ◯ Yes ◯ No _____
Do you have a history of chemical dependency or currently use controlled substances? ◯ Yes ◯ No _____

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Breast Feeding? ◯ Yes ◯ No Using prescription birth control? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin/Ibuprofen ☐ Codeine ☐ Cephalosporins ☐ Food Allergy ☐ Latex ☐ Local Anesthetics
☐ Metal or Acrylic ☐ Penicillin/Amoxicillin ☐ Sulfa drugs ☐ Seasonal
☐ Other Allergies: _____ ☐ No Known Allergies

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

Acid Reflux/GERD/Heartburn	◯ Yes ◯ No	Congenital Heart Disease	◯ Yes ◯ No	Learning Disability	◯ Yes ◯ No
ADHD	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Liver Disease/Hepatitis	◯ Yes ◯ No
AIDS/HIV Positive	◯ Yes ◯ No	Dry Mouth	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Alzheimer's or Dementia	◯ Yes ◯ No	Emphysema/COPD	◯ Yes ◯ No	Mental Health Care	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Anemia (Low Iron)	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Neurological Disorder	◯ Yes ◯ No
Angina or Chest Pain	◯ Yes ◯ No	Fainting/Dizziness	◯ Yes ◯ No	Obstructed Airway/Sleep Apnea	◯ Yes ◯ No
Anorexia or Bulimia	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Organ Transplant	◯ Yes ◯ No
Arthritis/Rheumatism/Gout	◯ Yes ◯ No	Headaches/Migraines	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Artificial Heart Valve*	◯ Yes ◯ No	Head or Neck Injury	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Artificial Joint*	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Heart Disease	◯ Yes ◯ No	Rheumatic Fever*	◯ Yes ◯ No
Autism	◯ Yes ◯ No	Heart Murmur*	◯ Yes ◯ No	Sinus Trouble/Surgery	◯ Yes ◯ No
Blood Disorder	◯ Yes ◯ No	Heart Pacemaker or Defibrillator	◯ Yes ◯ No	Snoring	◯ Yes ◯ No
Cancer/Growth/Tumor	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Stomach/Intestinal Condition	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Chronic Cough	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Thyroid or Parathyroid Problem	◯ Yes ◯ No
Cold Sores or Canker Sores	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Compromised Immune System	◯ Yes ◯ No	Kidney Problems/Dialysis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No

*The American Heart Association or American Academy of Orthopaedic Surgeons may suggest taking antibiotics prior to dental treatment.

Have you ever had any illness or condition that is not listed above? ◯ Yes ◯ No If yes, please explain:_____

Please explain YES answers from above:_____

_____

_____

_____

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 Prairie Dental Group of any changes in medical status. If I choose to print my name on forms, I accept this as my signature.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE_____

SIGNATURE OF DENTIST _____ DATE_____

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MEDICATIONS

Patient Name: _____

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.

Please list your medications, include both prescribed and over the counter.

Name of Medication	Reason for Use	Dosage / Frequency

To the best of my knowledge, the medications on this list are accurate. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any medication changes. If I choose to print my name on forms, I accept this as my signature.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE _____

SIGNATURE OF DENTIST_____ DATE _____

Dental History / Cavity Risk Factors

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www.prairiedental.com

Name: _____

Date: _____

How can we help you today?

_____

When was your last dental cleaning/visit? Reason?

_____

How do you feel your current dental health is? (check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do your gums bleed? ○ YES ○ NO

Have you ever had gum treatment? ○ YES ○ NO

Do you feel like your bite is off or has changed? ○ YES ○ NO

Have you had orthodontic treatment? ○ YES ○ NO

Do you wear retainers or a nightguard? ○ YES ○ NO

Do you clench or grind your teeth? ○ YES ○ NO

Do you currently or have you ever had pain/discomfort in your jaw joint (TMJ)? ○ YES ○ NO

Is there anything about your smile you would like to change if you could? ○ YES ○ NO

_____

Are your teeth sensitive to heat, cold, chewing or anything else? ○ YES ○ NO

Do you have any swelling, lumps or sores in your mouth? ○ YES ○ NO

Do you have any food trap areas? ○ YES ○ NO

Are you nervous about dental treatment? ○ YES ○ NO

Have you ever had an unfavorable dental experience in the past? ○ YES ○ NO

If yes, how can we accommodate you better in the future?

_____

Have you had a cavity in the last two years? ○ YES ○ NO

Do you have limited exposure to fluoride? (Well water or non-fluoride toothpaste) ○ YES ○ NO

Do you notice plaque build-up on your teeth between brushings? ○ YES ○ NO

Do you snack or drink any beverages (other than water) between meals? ○ YES ○ NO

If yes, please list: _____

Here at Prairie Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any service you would like to know more about.

☐ Invisalign/Orthodontics ☐ Whitening ☐ Dental Implants

☐ Cosmetic Dentistry ☐ Night/Sport Guards ☐ Sleep Apnea Prevention

☐ Cavity Prevention/Sealants ☐ Sedation Dentistry

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Consent for Use and Disclosure of Health Information

Patient Name: _____

To the Patient – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer
Paige Jechort
6608 Flying Cloud Drive
Suite 200
Eden Prairie, MN 55344
952-903-5000 FAX 952-944-0642
PaigeJ@prairiedental.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

CONSENT FOR USE AND DISCLOSURE:

I am aware this consent will remain in effect as long as I am a patient of record. I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

IF THIS CONSENT IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:

PERSONAL REPRESENTATIVE NAME: _____

RELATIONSHIP TO PATIENT: _____

If I choose to print my name on forms, I accept this as my signature.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

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6608 Flying Cloud Drive
Eden Prairie MN 55344
952-903-5000 (phone) 952-944-0642 (fax)
info@prairiedental.com

Authorization/Request for Dental Images

Please forward these images: Panorex/Full Series less than 5 years old
Bitewings less than 2 years old

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____
If I choose to print my name on forms, I accept this as my signature

Previous Dentist: _____

City/State: _____

Phone #: _____ Fax #: _____

Email:_____

FOR OFFICE USE:

Date Called: _____ Spoke To: _____ LM: _____ Office Closed: _____

BWs: _____ PANO/FMX: _____ PAs: _____

Perio Treatment: _____UR:_____LR:_____UL:_____LL:_____

Will be: Emailed: _____ Mailed: _____ Request Sent via: _____ By: _____

NOTES:_____

Date Received: _____ Walked-Out: _____ Follow up: _____