

Patient Registration / Adult

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		How do you wish to be addressed?		Date of Birth	
Address		City		State	Zip
Home Phone #		Social Security #		Driver's License #	
Cell #					
Email:					
Mark appropriate box: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered					

Account Information

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

Insurance		Primary Dental Insurance Company _____	
Name of Policyholder _____		Policy # _____	
Primary Policyholders birth date _____		Social Security # _____	
		Secondary Dental Insurance Company _____	
Name of Policyholder _____		Policy # _____	
Secondary Policyholders birth date _____		Social Security # _____	
If Welfare, agency and case# _____			

Someone not living with you to contact in case of emergency (name and 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.

Patient Signature _____ Date _____

Health Record / Adult

Patient Name

File #

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

Dental History

Reason for this visit:

Previous dentist (name and location)

When was your last dental visit?

What was done then?

How often did you visit the dentist before then?

Have you had a complete series of dental films (x-rays) taken?
 Yes No When? _____ Where? _____

What types of dental treatment have you had in the past?

How often do you brush your teeth?

How often do you floss your teeth?

Is there anything about your teeth that you would change if you could?

Do you snack between meals? Yes No
 What types of food? _____

Do any of the following apply to you?

Please ✓

- Yes No Tooth sensitivity:
 Hot Cold Sweets Chewing/pressure _____
- Yes No Toothache _____
- Yes No Teeth removed _____
- Yes No Unpleasant dental experience _____
- Yes No Gums bleed or sore _____
- Yes No Loose teeth _____
- Yes No Mouth odor or bad taste _____
- Yes No Food trap area _____
- Yes No Swelling, lumps or sores in mouth _____
- Yes No Grind or clench teeth _____
- Yes No Jaw joint pain or noise _____
- Yes No Jaw locks _____
- Yes No Bite is off/crowded teeth _____
- Yes No Orthodontic treatment. When? _____
- Yes No Injuries to head, neck or jaw _____
- Yes No Other: _____
- Yes No Are you happy with the appearance of your teeth? _____

Medical History

Physician (name and address)

Please ✓

- Yes No Are you presently under a physician's care? If yes, why? _____
 When was your last physical examination? _____
- Yes No Have you ever been hospitalized or had a serious illness or accident? Please explain: _____
- Yes No Are you taking any drugs or medications? If yes, please list on medications page.
- Yes No Are you allergic to any medications?
 Penicillin Codeine Local anesthetic Other: _____
- Yes No Women: Are you pregnant? If yes, how long? _____ Nursing? _____
- Yes No Women: Are you taking birth control pills?
- Yes No Do You: Smoke? Use chewing tobacco?

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

Please ✓

- | | | |
|---|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart (disease, attack, surgery) | <input type="checkbox"/> Yes <input type="checkbox"/> No Anema | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain | <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS/HIV positive | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent/severe headaches |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital heart defect | <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial joint/prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No Chemical dependency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Lung disease (TB, emphysema)
Active, Latent | <input type="checkbox"/> Yes <input type="checkbox"/> No Nervous/anxious |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma/hay fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Mental health care |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral valve prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No Tumor/cancer |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial heart valve | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation therapy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart pacemaker/Defibrillator | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Circulatory problem | <input type="checkbox"/> Yes <input type="checkbox"/> No Cold sores/fever blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid problem |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies/hives | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney problem |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Latex sensitivity | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver problem |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis/rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bruise easily | <input type="checkbox"/> Yes <input type="checkbox"/> No Back problem | <input type="checkbox"/> Yes <input type="checkbox"/> No G.E.R.D. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting spells | <input type="checkbox"/> Yes <input type="checkbox"/> No Gastro-intestinal |

Yes No Do you have any disease, condition or problem not listed? Please explain: _____

Yes No Has it ever been recommended that you be premedicated for any of the above conditions?
 If yes, reason: _____

The above information is correct to the best of my knowledge.

Patient Signature _____ Date _____

D.D.S. Signature _____ Date _____

UPDATES (Staff use) Note changes in medical history, dental history or address and phone number.	<input type="checkbox"/> No Change <input type="checkbox"/> Refer Progress Notes Signed: _____ <input type="checkbox"/> Date _____	<input type="checkbox"/> No Change <input type="checkbox"/> Refer Progress Notes Signed: _____ <input type="checkbox"/> Date _____	<input type="checkbox"/> No Change <input type="checkbox"/> Refer Progress Notes Signed: _____ <input type="checkbox"/> Date _____
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Prairie Dental Group
6608 Flying Cloud Drive, Suite 200
Eden Prairie, MN 55344
(952) 903-5000

Thank you for choosing Prairie Dental Group. At your initial visit, we will review your health history with you to ensure we are providing you with the best individualized care possible. Some medications may interact with the anesthetics or other medications prescribed by your dentist. We know the names of some medications can be lengthy or hard to remember; so please take a few minutes to jot down any medications that you are currently taking (prescribed or over the counter) and bring this information with you to your first visit.

Date	Name of Medication	Dosage	Frequency	Reason for use	Staff Initial

We look forward to meeting you. If you have any questions, please feel free to give us a call. We would love to help anyway we can. Thank You.

Printed Name

Signature

Date

Prairie Dental Group

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Print Patient's 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 accompanies this Consent. 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 Person: Caryl
Telephone: (952) 903-5000 Fax: (952) 944-0642
E-mail: caryl@prairiedental.com Address: 6608 Flying Cloud Dr., Eden Prairie, MN 55344

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 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 health care operations.

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.