

Patient Registration / Child or Teen

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		Nickname (if any)		Date of Birth		
Address			City		State	Zip
Home Phone #		School/Grade		Hobbies/Pets/Interests		

Account Information

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

Insurance

Primary Dental Insurance Company _____	Policy # _____
Name of Policyholder _____	Social Security # _____
Secondary Dental Insurance Company _____	Policy # _____
Name of Policyholder _____	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 for my child 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.

Signature of Parent or Guardian _____ Date _____

Health Record / Child or Teen

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 your drinking water fluoridated? Yes No

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 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? _____
- Yes No Have you ever been hospitalized or had a serious illness or accident? Please explain: _____
- Yes No Are you taking any drugs or medication? If yes, please list: _____
- Yes No Are you allergic to any medications?
- Penicillin Codeine Local anesthetic Other: _____
- 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 Anemia | <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) | <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 | <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 Tonsillitis |
| <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 Ulcers |
| <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 Other: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting spells | |

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.

Signature of Parent or Guardian _____ 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 _____	<input type="checkbox"/> No Change <input type="checkbox"/> Refer Progress Notes Signed: _____ <input type="checkbox"/> Date _____
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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.**