PATIENT INFORMATION

Name:_____Date_____
First M Last

(Circle) Married/Single Male/Female Birthdate_____ SS#_____

Address_____
Street Apt # City State Zip Code

Home Phone_____ Work _____ Cell_____

☐ Leave Detailed Message ☐ Leave Message with Call-back Info Only

Place of Employment_____

Email Address_____

Has any member of your family ever been treated in our office? ☐Yes ☐ No

Whom may we thank you for referring you to our office_____

Name of Dental Insurance_____ Group #_____

Subscriber Name_____Employer_____Birthday_____Subscriber ID_____

Emergency Contact_____Relationship_____Phone_____

MEDICAL HISTORY

Medical Doctor's Name, Clinic Name, Telephone_____

Are you under a doctor's care now or have you been hospitalized in the last 2 years? If yes, please explain
_____

Please list, or provide a list, of any medications, pills, or drugs, including herbal supplements you are currently taking_____

Are you allergic to any medications or substances? If yes, please list_____

Do you use any tobacco products? Is yes, please list type and frequency_____

Have you ever take the diet medication Fen-Phen----------☐Yes ☐ No

Have you ever taken Osteoporosis Medication (Fosamax, Actonel, Boniva)---------- ☐ Yes ☐ No

Are you currently pregnant----------☐ Yes ☐ No

Artificial Joints? Date of Placement_____Physician----------☐ Yes ☐ No

Please CIRCLE if you have had any of the following:

Heart Trouble	Developmental Disability	Liver Disease	Collitis
Heart Murmur	Autism	Tuberculosis	Thyroid Disease
Pacemaker	Alzeheimers/Dementia	Chemotherapy	Celiac Disease
High/Low Blood Pressure	Drug/Alcohol Addiction	Radiation Treatment	Blood Disease
Chest Pain	Diabetes	Scarlet Fever	Drug Addiction
Congenital Heart Lesions	Cancer	Psychiatric Care	Hemophilia
Artificial Heart Valve	Hepatitis	Venereal Disease	Herpes
Excessive Bleeding	HIV/Aids	Glaucoma	Sickle Cell Disease
Blood Thinner Medication	Anemia	Cortisone Medicine	Kidney Disease
Stroke	Ulcers	Cerebal Palsy	Cold Sores
Dizziness/Fainting	Asthma	Epilepsy/Seizures	

AUTHORIZATION

I understand that in case of accidental injury or poke to a Dakota Dental employee, a blood test may be required at our expense. I hereby authorize payment directly to Dakota Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize Dakota Dental to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize for Dakota Dental to contact me at the above listed numbers. The information on this page is correct to the best of my knowledge.

Signature of Patient/Guardian:_____

Relationship to Patient_____