4701 Nicollet Avenue
Minneapolis, MN 55419
(612) 824-4211
www.AllBeautifulSmiles.com

PATIENT REGISTRATION FORM

Today's Date: ______________________________ E-mail address: ______________________________

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

GETTING TO KNOW YOU

NAME: ____
LAST FIRST MIDDLE

Birthdate: ____/____/______ Age: _____ SSN:______________________

Home Address: ____
Street **City** **State** **Zip**

Home Phone: (____)____________ Business Phone (_____)____________

Cell Phone: (____)_________________

I prefer to be contacted by: ☐ Home Phone ☐ Business/Cell Phone ☐ E-mail

EMPLOYER: ____

Work Address: ___________________________Occupation: ____________

Please tell us how you heard about our office ______________________

Spouse Information: Name: ____________________ DOB: ____________

Employer: ______________________ Position: ______________________

Work Phone: ______________________ SSN: ______________________

Emergency Contact Name: _______________ Relationship: _____________

Home Phone: _________________ Work/Cell Phone:_________________

Person Responsible for Account (if other than yourself)

Name: _________________________ Relationship: _________________

Home Phone: __________________ Work Phone: __________________

Employer: ________________________ SSN: ______________________

INSURANCE INFORMATION

Primary Dental insurance: ☐ Yes ☐No

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone: ______________________

Group #: __________ Policy #: ______________

Insured's Name: ______________________

Relation to the insured: ______________________

Insured's Birthdate: ____/____/_____

Insured's SSN: ______________________

Insured's Employer: ______________________

Secondary Dental insurance: ☐ Yes ☐No

ACKNOWLEDGMENT

I certify that I (or my dependent) have insurance coverage with the above named insurance company (companies) and assign directly to Parkway Dental all insurance benefits. I understand that I am financially responsible for all charges: any deductible amount, Co-insurance, or any balance not paid for my insurance company (if I may have one). I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ______________________

Please fill in completely:

DENTAL HISTORY

Reason for Today's Visit:______________________________

Former Dentist's Name: ____________________________

Date of last dental visit: ____________________________

Date of last dental X-Ray: ____________________________

MEDICAL HISTORY

Your Physician's Name: ____

Phone number: _______________ Date of Last Visit: ___________________

Is there any Medical or Dental information you feel we should know about?

☐ Yes, please explain____ ☐ No

Please mark "**Yes**" or "**No**" indicating if you have or have had any of the following:

Condition	Yes	No
Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of the mouth	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Food collection between your teeth	☐ Yes	☐ No
Earaches	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain when brushing	☐ Yes	☐ No
Orthodontic treatment (braces)	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sores or growth in your mouth	☐ Yes	☐ No
Sensitivity to (if yes, please circle): cold, heat, sweets, when chewing	☐ Yes	☐ No
Do you regularly brush?	☐ Yes	☐ No
Do you regularly use floss?	☐ Yes	☐ No

Condition	Yes	No	Condition	Yes	No
Bleeding abnormally with extractions or surgery	☐ Yes	☐ No	AIDS	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No	Psychiatric care	☐ Yes	☐ No
Back problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Chemical dependency	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Circulatory problems	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Congenital heart lesions	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
HIV positive	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Cortisone treatments	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Cough (persistent or bloody)	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Neck pain	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No	Skin rash	☐ Yes	☐ No
Hepatitis type ________	☐Yes	☐ No	Special diet	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No	Artificial heart valve	☐ Yes	☐ No
Mitral valve prolapse	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Nervous problems	☐ Yes	☐ No	Scarlet fever	☐ Yes	☐ No
Respiratory disease	☐ Yes	☐ No	Sinus trouble	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Feet/Ankle swelling	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Swollen neck glands	☐ Yes	☐ No	Tumor/growth on head or neck	☐ Yes	☐ No
Unexplained weight loss	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Due date: ____________

Are you nursing? ☐ Yes ☐ No

MEDICATIONS

Please list medications you are currently taking:

____

Pharmacy : ________________ Phone #: _____________

ALLERGIES

☐ Aspirin ☐ Local Anesthetic
☐ Barbiturates (Sleeping Pills) ☐ Latex
☐ Codeine ☐ Penicillin
☐ Erythromycin ☐Sulfa
☐ Iodine ☐Other ___________

REMARKS (Doctor Only):

____

____

____

AUTHORIZATION AND CONSENT

I confirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in strictest confidence and it is my responsibility to inform the office of any changes.

I hereby authorize the Doctor to take x-rays, study models, photographs or any other diagnostics aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform dental treatment, medication, and therapy that may be indicated. I also understand that all dental procedures and the use of anesthetic agents carry a certain risk.

CONSENT (if child or minor): ________________ I hereby authorize the necessary dental treatment to be performed for the child named above.

Name: __________________**Signature:** _____________ _____**Date:** _______