PARKWAY DENTAL CENTER
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 #: _____ _____

Insured's Name: _____

Relation to the insured: _____

Insured's Birthdate: ____/____/_____

Insured's ID#/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:

Bad breath……..	☐ Yes	☐ No	Bleeding abnormally with extractions or surgery……..	☐ Yes	☐ No	AIDS……	☐ Yes	☐ No
Bleeding gums……..	☐ Yes	☐ No				Psychiatric care…	☐ Yes	☐ No
Blisters on lips or mouth……..	☐ Yes	☐ No	Artificial joints……	☐ Yes	☐ No	Radiation		
Burning sensation on tongue……	☐ Yes	☐ No	Back problems ……	☐ Yes	☐ No	Treatment……	☐ Yes	☐ No
Chew on one side of the mouth……	☐ Yes	☐ No	Headaches……..	☐ Yes	☐ No	Anemia……	☐ Yes	☐ No
Cigarette, pipe or cigar smoking……..	☐ Yes	☐ No	Hemophilia……..	☐ Yes	☐ No	Arthritis……	☐ Yes	☐ No
Clicking or popping jaw……	☐ Yes	☐ No	Chemical dependency…..	☐ Yes	☐ No	Asthma……	☐ Yes	☐ No
Dry mouth……	☐ Yes	☐ No	Chemotherapy……..	☐ Yes	☐ No	Cancer……	☐ Yes	☐ No
Food collection between your teeth……	☐ Yes	☐ No	Circulatory problems……	☐ Yes	☐ No	Diabetes……	☐ Yes	☐ No
Earaches……	☐ Yes	☐ No	Congenital heart lesions	☐ Yes	☐ No	Epilepsy……	☐ Yes	☐ No
Grinding teeth……	☐ Yes	☐ No	HIV positive……	☐ Yes	☐ No	Glaucoma……	☐ Yes	☐ No
Gums swollen or tender……	☐ Yes	☐ No	Cortisone treatments ….	☐ Yes	☐ No	Herpes……	☐ Yes	☐ No
Jaw pain or tiredness……	☐ Yes	☐ No	Cough (persistent or bloody)……..	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Lip or cheek biting ……	☐ Yes	☐ No				Neck pain……	☐ Yes	☐ No
Loose teeth or broken fillings……	☐ Yes	☐ No	Emphysema……	☐ Yes	☐ No	Jaundice……	☐ Yes	☐ No
Mouth breathing ……	☐ Yes	☐ No	Fainting or dizziness……	☐ Yes	☐ No	Pacemaker……	☐ Yes	☐ No
Mouth pain when brushing……	☐ Yes	☐ No	Heart murmur……	☐ Yes	☐ No	Skin rash……	☐ Yes	☐ No
Orthodontic treatment (braces)……	☐ Yes	☐ No	Heart problems ……	☐ Yes	☐ No	Special diet……	☐ Yes	☐ No
Periodontal treatment……	☐ Yes	☐ No	Hepatitis type _____	☐Yes	☐ No	Stroke……	☐ Yes	☐ No
Sores or growth in your mouth……	☐ Yes	☐ No	Kidney disease ……	☐ Yes	☐ No	Ulcer……	☐ Yes	☐ No
			Liver disease ……	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
			High blood pressure	☐ Yes	☐ No	Artificial heart		
Sensitivity to (if yes, please circle): cold, heat, sweets, when chewing……	☐ Yes	☐ No	Low blood pressure	☐ Yes	☐ No	valve……	☐ Yes	☐ No
Do you regularly brush? ……	☐ Yes	☐ No	Mitral valve prolapse	☐Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Do you regularly use floss? ……	☐ 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		
			Unexplained weight loss	☐ Yes	☐ No	head or neck……	☐ 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 & Number:_____

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 know - ledge. 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.

NAME:_____**DATE:**_____

SIGNATURE:_____

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