

Welcome!

E-Mail Address: _____

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

Patient Information

Name _____ Birthdate _____ SS # _____

How would you like to be addressed? _____

Address _____ City _____ St. _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ ext _____ Cell Phone _____

Employer _____ Occupation _____

Check Appropriate Box: male female single married other

Spouse's name _____ Birthdate _____

Employer _____ Work Phone _____

Whom may we thank for referring you to our office? _____

Person to contact in case of emergency _____ Phone _____

Account Information (Please present your insurance card or claim form at your visit.)

Primary Dental Insurance _____ Group # _____

Name of Policyholder _____ Social Security # _____

Secondary Dental Insurance _____ Group # _____

Name of Policyholder _____ Social Security # _____

The information I have provided to Cherrywood Dental Care is correct to the best of my knowledge.

I give my consent to Cherrywood Dental Care to discuss with my spouse, family members, or guardian information to facilitate my treatment and/or payment on my account.

I hereby authorize Cherrywood Dental Care to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-determination of treatment plan fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Cherrywood Dental Care for the services rendered to me by either the doctor or the staff. I understand that I am ultimately responsible for the total cost of my services.

I understand 48 business hours notice are needed when cancelling or rescheduling an appointment. Failure to do so may result in a \$50.00 cancellation fee.

I agree to be responsible for payment of all services rendered on my or my dependant's behalf, and I understand finance charges may be added to remaining balances over thirty (30) days. I am aware that there will be an additional charge of 40% of my bill in the event my account is turned over to a collection agency and the Credit Bureau of Minneapolis/St. Paul.

I have received a copy of this office's Notice of Privacy Practices.

Signature of Patient/Guardian _____ Date _____

Medical Information

Patient Name _____ Birthdate _____

Thank you for choosing our office to care for your dental health. In order to serve you properly, we ask that you complete the following medical and dental history sections. Thank you.

Physician name & location _____		phone _____						
Are you presently under a physician's care? yes no Explain _____								
Have you ever had a serious illness or accident? yes no Explain _____								
List any medications/drugs & dosages that you are taking. _____								
Are you allergic to: Penicillin Erythromycin Sulfa Local Anesthetic Latex Other _____								
Do any of the following apply to you now or in the past?								
Heart disease	yes	no	Hepatitis	yes	no	Jaundice	yes	no
Circulatory problems	yes	no	Arthritis	yes	no	Nervousness	yes	no
Congenital heart defect	yes	no	Mental health care	yes	no	Venereal disease	yes	no
Abnorm blood pressure	yes	no	Cold sores	yes	no	Radiation therapy	yes	no
Diabetes	yes	no	Anemia	yes	no	Sinus trouble	yes	no
Asthma/hay fever	yes	no	Kidney problems	yes	no	Thyroid problem	yes	no
Tumors	yes	no	AIDS/HIV positive	yes	no	Epilepsy/seizures	yes	no
Ulcers	yes	no	Abnormal bleeding	yes	no	Back problems	yes	no
Stroke	yes	no	Blood transfusion	yes	no	Chemical dependency	yes	no
Prosthetic implant	yes	no	Glaucoma	yes	no	Fainting spells	yes	no
Tuberculosis	yes	no	Headaches	yes	no	Pregnant (Currently)	yes	no
Have you ever been advised to be premedicated prior to dental treatment for any of the above? yes no								

The medical information that I have provided Cherrywood Dental Care is correct to the best of my knowledge. I authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby give my consent to Cherrywood Dental Care to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature of Patient/Guardian _____ Date _____

For office use only:

Date: _____ <input type="checkbox"/> No Medical Changes <input type="checkbox"/> See Progress Notes Pt. Int. _____ Dr. _____	Date: _____ <input type="checkbox"/> No Medical Changes <input type="checkbox"/> See Progress Notes Pt. Int. _____ Dr. _____	Date: _____ <input type="checkbox"/> No Medical Changes <input type="checkbox"/> See Progress Notes Pt. Int. _____ Dr. _____
Date: _____ <input type="checkbox"/> No Medical Changes <input type="checkbox"/> See Progress Notes Pt. Int. _____ Dr. _____	Date: _____ <input type="checkbox"/> No Medical Changes <input type="checkbox"/> See Progress Notes Pt. Int. _____ Dr. _____	Date: _____ <input type="checkbox"/> No Medical Changes <input type="checkbox"/> See Progress Notes Pt. Int. _____ Dr. _____

Dental History

What prompted you to schedule your visit today? _____

When was your last dental visit? _____

Have you ever had any serious problem associated with previous dental treatment? Yes No

If so, please explain _____

Do you avoid brushing any part of your mouth because of pain? Yes No

If yes, what part? _____

Do you feel twinges of pain when your teeth come in contact with HOT COLD SWEET SOUR

Do you chew on only one side of your mouth? Yes No

If yes, explain _____

On a scale of 1-10, 10 being the highest, what priority do you give your teeth? _____

How often do you brush your teeth? _____

How often do you floss? _____

Do your gums bleed while brushing? Yes No

Do your gums bleed while flossing? Yes No

Do you feel pain to any of your teeth when brushing or flossing them? Yes No

Do you have any pain in any part of your mouth or in any tooth while biting or chewing? Yes No

Do your gums feel tender or swollen? Yes No

Do you usually have many cavities? Yes No

Do you lose fillings or break fillings? Yes No

Do you gag easily? Yes No

Do you feel your bite is off (bad bite)? Yes No

Does food catch between your teeth? Yes No

Do you eat a piece of candy or chocolate every day? Yes No

Do you drink regular soft drinks or chew regular gum every day? Yes No

Do you smoke or chew tobacco? Yes No

Have you ever had problems with your TMJ (jaw joint)? Yes No

Are you in the habit of biting your nails or any other hard object? Yes No

Do your jaws ever feel tired when you wake up, talk, or chew a lot? Yes No

Do you ever have pain, clicking, popping or grating sounds from your jaw joint? Yes No

Does it hurt when you open wide or take a big bite? Yes No

Does your jaw ever lock or go out; i.e., get stuck open or closed? Yes No

Does your jaw make a noise so that it bothers you or others? Yes No

Do you ever have ringing or pain in your ears? Yes No

Do you have chronic earaches? Yes No

Do you grind your teeth during the day or night? Yes No

Do you wear a nightguard? Yes No

Have you ever had orthodontics (braces)? Yes No

Have you ever had periodontal therapy (gum surgery)? Yes No

Have you ever been treated by an oral surgeon? Yes No

Are you happy with your past dentistry? Yes No

Are you happy with the appearance of your teeth? Yes No

What is the one thing that you liked least about any former dentist or office? _____

What is the one thing that you liked most about any former dentist or office? _____