



# PERSONAL INFORMATION

## 1. ABOUT YOU

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

I prefer to be addressed as: \_\_\_\_\_

Home Address: \_\_\_\_\_

City, Zip: \_\_\_\_\_

Pager/Mobile # \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ ext: \_\_\_\_\_

May we contact you at this work phone?  Yes  No

Email address(es) \_\_\_\_\_

(We like to e-mail our patients quarterly about dental health updates, specials and updated tools on our website. Please share your email address – which will be kept confidential.)

If we send a children's email update would that be of interested to your household?

Yes  No

(please check):  Male  Female  Single  Married  Widowed  
 Divorced  Domestic Partnered

Date of Birth: \_\_\_\_\_

Drivers License # \_\_\_\_\_

(note, we cannot take checks from those who do not provide their drivers license #)

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Other family and household members at Maple Grove Family Dental: \_\_\_\_\_

Whom may we thank for referring you?  Dr. Nelson  Phone Book  Website

Referral from another patient: (name) \_\_\_\_\_

Other: \_\_\_\_\_

## 2. SPOUSE/EMERGENCY INFO

Spouse/Partner: \_\_\_\_\_

Employer: \_\_\_\_\_

Cell#: \_\_\_\_\_

Work #: \_\_\_\_\_ Ext.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

In the event of an emergency, is there someone other than a spouse you would like us to contact?

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Work #: \_\_\_\_\_ Ext.: \_\_\_\_\_

## 3. FINANCIAL INFO

If other than yourself, please list the person responsible for the account and their information below:

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Home #: \_\_\_\_\_

Work #: \_\_\_\_\_ ext.: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Employer Name: \_\_\_\_\_

## 4. INSURANCE INFO

**Primary Dental Coverage** Insurance Co.: \_\_\_\_\_

Phone #: \_\_\_\_\_

Group Name: \_\_\_\_\_

Group #: \_\_\_\_\_

Subscriber #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**Secondary Dental Coverage** Insurance Co.: \_\_\_\_\_

Phone #: \_\_\_\_\_

Group Name: \_\_\_\_\_

Group #: \_\_\_\_\_

Subscriber #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**Tertiary Dental Coverage** Insurance Co.: \_\_\_\_\_

Phone #: \_\_\_\_\_

Group Name: \_\_\_\_\_

Group #: \_\_\_\_\_

Subscriber #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**Medical Coverage** Insurance Co.: \_\_\_\_\_

Phone #: \_\_\_\_\_

Group #: \_\_\_\_\_

ID #: \_\_\_\_\_

I authorize release of any information relating to claims filed by **Maple Grove Family Dental**.

Signature: \_\_\_\_\_

I wish to assign benefits to Maple Grove Family Dental and understand that I am responsible for any co-payment and deductibles that my insurance does not cover.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_





# DENTAL INFORMATION

## 1. MEETING PATIENT'S IMMEDIATE NEEDS

Patient Name: \_\_\_\_\_

What brings you here today?  Check-up Time  Problem  Other (explain): \_\_\_\_\_

Why are you changing dental offices?  Insurance  Location  Didn't Like

Other (explain): \_\_\_\_\_

Do you have problems with your teeth now?  Yes  No

If Yes (check):  Hot  Cold  Sweet  Food-Caught  Broken Tooth  Other

## 2. PAST DENTAL HISTORY

When was the last time you saw a dentist?  1st visit  6 mo.  1 yr.  2 yrs.  3+ yrs.

What treatment did you receive?  Preventive  Basic Fillings  Major Restoration

Was that a comfortable experience?  Yes  No

Why? \_\_\_\_\_

Did you have any treatment that was recommended but not yet completed?  Yes  No

If yes: \_\_\_\_\_

## 3. HOME CARE & PERIO HISTORY

What do you do at home to take care of your oral health?

Brush; How often: \_\_\_\_\_  Floss; How often: \_\_\_\_\_ Mouthwash:  Yes  No

Any bleeding when you brush or floss your teeth?  Yes  No

Concerned about (check)  Bad Breath  Taste

Other (explain): \_\_\_\_\_

## 4. COSMETIC

Are you happy with your smile?  Yes  No

Anything you would like to change if you could?  Color  Shape  Position

Detail (if needed) \_\_\_\_\_

## 5. FEARS OR ANXIETIES

Is there anything you don't like about dental appointments?

Discomfort  Fee  Time Inconvenience  Afraid  Other (explain): \_\_\_\_\_

## 6. LIFETIME SMILE PLAN

The way we practice dentistry is something we call "Lifetime Smile Plan." What that means is that we provide you with enough education about the health of your mouth so that you can make choices for yourself. This allows you to save your teeth for the rest of your life, while being happy about the way they LOOK and FEEL.

We are going to teach you about what is HEALTHY and UNHEALTHY, and we will provide you with the alternatives to treating the unhealthy areas. We will inform you of the risks, advantages and disadvantages of treating or not treating your teeth as well. One of the alternatives will always be "TO DO NOTHING." We will always inform you of your costs and what you can expect from your insurance before you schedule your treatment, so there will never be any surprise.

Other Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

