1870 W. Wayzata Blvd
PO Box 695
Long Lake, MN 55356

Ph: 952-473-7151
Fax: 952-475-1539
longlakedental@uslink.net

Patient Information

Name: _____ Date: _____
Last, First, Middle Initial

Date of birth: _____ Person Responsible for the Account:

Address: _____ _____

City, State, Zip: _____ Relationship to Patient (Please Circle):

Home Phone: _____ Self Spouse Child Other _____

Cell Phone: _____

Work Phone: _____ Employed by: _____

Email Address: _____ Occupation: _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

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

Dental History

Date of Last Dental Exam: _____

Chief Dental Complaint: _____

Do you have or Have You Had Any of the Following? (Please Circle All That Apply)

Sensitivity to hot or cold	Broken Fillings	Other Teeth Extracted
Sensitivity to sweets	Periodontal Treatment	Missing Teeth Not Replaced
Sensitivity to pressure	Negative Dental Experiences	Orthodontic Treatment
Clicking/popping when opening jaw	Pain In or Near Ears	Prolonged Bleeding After Extraction
Clenching or Grinding	Swelling or Lumps in Mouth	
Food packing	Wisdom Teeth Extracted	

Medical History

Physicians Name: _____ Women: Are you Pregnant? Yes No

Date of Last Medical Examination _____ Due Date: _____

Do You Have or Have You Had Any of the Following? (Please Circle All That Apply)

Artificial Heart Valve	Stroke	Diabetes	Psychiatric Care
Heart Ailments	Neurologic Problems	Liver Problems or Hepatitis	Emotional Problems
High Blood Pressure	Cancer	Kidney Problems Cataracts	Ulcers or Colitis
Pacemaker	Malignancies	Rheumatic Fever	Arthritis
Asthma	Chemotherapy	Tuberculosis	Joint Replacement
Sinus Problems	Radiation Treatment	Anemia or Blood Problems	HIV/AIDS

Any illness or surgery not listed? Yes No If yes, Please list _____
Allergies to drugs/anesthetics? Yes No If yes, Please list _____

Continued on Back – Over Please

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Insurance Information

Subscriber Name: _____ Subscriber Date of birth: _____

Patient Relationship to Subscriber (Please Circle): Self Spouse Child Other: _____

Name of Insurance Company: _____ Group #: _____

Claims Address for Insurance Company: _____

Subscriber Social Security number: _____ Subscriber ID Number: _____

Employer Name: _____

Employer Address: _____

Secondary Insurance

Do you have another Dental Policy? Yes No

Subscriber Name: _____ Subscriber Date of birth: _____

Patient Relationship to Subscriber (Please Circle): Self Spouse Child Other: _____

Name of Insurance Company: _____ Group #: _____

Claims Address for Insurance Company: _____

Subscriber Social Security number: _____ Subscriber ID Number: _____

Employer Name: _____

Employer Address: _____

Insurance Signature on File

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed this particular claim.

_____

Patient/Guardian Signature Date