

Patient Information

(Please Print)

Name _____ Date _____ SSN# _____

Address _____ Phone _____ (cell)

_____ (home)

_____ (work)

Email Address _____

Birthdate _____ Sex _____ M _____ F

Spouse or Parent's Name _____ Phone _____

Emergency Contact _____ Phone _____

Employer _____ Occupation _____

Responsible Party

Name of Person Responsible for this Account _____

Relationship to Patient _____

Primary Insurance Information

Name of Insured _____ SSN#/Subscriber ID# _____

Birthdate _____ Name of Employer _____

Insurance Company _____ Group ID# _____

Secondary Insurance Information

Name of Insured _____ SSN#/Subscriber ID# _____

Birthdate _____ Name of Employer _____

Insurance Company _____ Group ID# _____

Smile Evaluation

Please Circle

Do you like the way your teeth look?	Yes	No
Are you happy with the color of your teeth?	Yes	No
Would you like for your teeth to be whiter?	Yes	No
Would you like for your teeth to be straighter?	Yes	No
Do you have spaces between your teeth that you would like closed?	Yes	No
Would you like your teeth to be longer?	Yes	No
Do you like the shape of your teeth?	Yes	No
Do you have missing teeth that you would like to replace?	Yes	No
Do you have old silver fillings that you would like to replace with tooth-colored fillings?	Yes	No
If you could change anything about your smile, what would you change?		

Medical History

Physician _____ Phone# _____

Please list all medications you are currently taking _____

(Women) Are you pregnant? Yes/No Nursing? Yes/No Taking birth control pills? Yes/No

Check if you have had any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cough
Blood | <input type="checkbox"/> Psychiatric
Care | Have you taken any of
the following
medications |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation
Treatment | |
| <input type="checkbox"/> Arthritis,
Rheumatism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Respiratory
Disease | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Artificial Heart
Valves | <input type="checkbox"/> Fainting | <input type="checkbox"/> Rheumatic
Fever | <input type="checkbox"/> Diet
Medications |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Heart
Medications |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of
Breath | If you have, please list
below |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Skin Rash | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Swelling of | _____ |
| <input type="checkbox"/> Chemical
Dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid
Problems | _____ |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Tobacco Habit | Allergies: |
| <input type="checkbox"/> Circulatory
Problems | <input type="checkbox"/> High Blood
Pressure | <input type="checkbox"/> Tonsillitis | _____ |
| <input type="checkbox"/> Congenital
Heart Lesions | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Cortisone
Treatments | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Ulcer | _____ |
| <input type="checkbox"/> Cough,
Persistent | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Venereal
Disease | _____ |
| | <input type="checkbox"/> Liver Disease | | |
| | <input type="checkbox"/> Mitral Valve
Prolapse | | |
| | <input type="checkbox"/> Nervous
Problems | | |
| | <input type="checkbox"/> Pacemaker | | |

Dental History

Previous Dentist Name _____ Date of last Exam _____

How often do you brush? _____ Floss? _____

Please check any of the following conditions that apply to you:

- | | |
|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Previous periodontal treatment |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Sensitivity to Cold |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Sensitivity to Heat |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sores or growths in your mouth |

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Dr. Marty W. Lindahl may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits.

Signature _____ Date _____