Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

ABOUT YOU

TODAY'S DATE _____

NAME _____ DATE OF BIRTH _____ ☐ MALE ☐ FEMALE NICKNAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

MAY WE CALL YOU AT YOUR WORK NUMBER REGARDING YOUR DENTISTRY? ☐ YES ☐ NO EMAIL _____

ARE YOU ☐ MINOR ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE ☐ SEPARATED

YOUR SOCIAL SECURITY NUMBER _____

(IF DIFFERENT FROM ABOVE)

NAME OF PERSON RESPONSIBLE FOR PAYMENT ON ACCOUNT _____

RESPONSIBLE PARTY HOME PHONE _____ SOCIAL SECURITY NUMBER _____

YOUR OR YOUR PARENTS EMPLOYER _____ OCCUPATION _____

SPOUSE OR PARENTS NAME _____ WORKPLACE _____ WORK PHONE _____

IF YOU ARE A STUDENT, NAME OF SCHOOL OR COLLEGE _____ CITY _____ STATE _____

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU _____ PHONE _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

DO YOU HAVE A 2ND INSURANCE COVERAGE? ☐ YES ☐ NO

PREVIOUS DENTIST _____ PHONE _____ DATE OF LAST EXAM & XRAYS _____

NEW PATIENT - WHY HAVE YOU COME TO THE DENTIST TODAY? _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

DENTAL INSURANCE

PATIENT'S PRIMARY INSURANCE

INSURANCE CO. NAME _____ GROUP # (PLAN, LOCAL OR POLICY #) _____

INSURANCE CO. ADDRESS _____ PHONE _____

INSURED'S NAME _____ PATIENT'S RELATION TO INSURED _____ INSURED'S D.O.B. _____

INSURED'S EMPLOYER _____ INSURED'S SOCIAL SECURITY NUMBER _____

PATIENT'S SECONDARY INSURANCE

INSURANCE CO. NAME _____ GROUP # (PLAN, LOCAL OR POLICY #) _____

INSURANCE CO. ADDRESS _____ PHONE _____

INSURED'S NAME _____ PATIENT'S RELATION TO INSURED _____ INSURED'S D.O.B. _____

INSURED'S EMPLOYER _____ INSURED'S SOCIAL SECURITY NUMBER _____

MEDICAL HISTORY

YOUR CURRENT PHYSICAL HEALTH IS: ❑GOOD ❑FAIR ❑POOR

PLEASE EXPLAIN _____

ARE YOU TAKING ANY PRESCRIPTION/OVER-THE-COUNTER MEDICATIONS? ❑YES ❑NO BLOOD THINNERS ❑YES ❑NO

PLEASE LIST EACH MEDICATION _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

DO YOU HAVE A PERSONAL PHYSICIAN? ❑YES ❑NO - PHYSICIAN'S NAME _____ PHONE # _____ DATE OF LAST VISIT _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL CONDITIONS?

Y N AUTISM
Y N AIDS
Y N ANEMIA
Y N ARTHRITIS / RHEUMATISM
Y N ARTIFICIAL HEART VALVES - PREMED NEEDED?_____
Y N ASTHMA
Y N BACK PROBLEMS
Y N BLOOD DISEASE
Y N BLOOD PRESSURE (❑ HIGH or ❑ LOW)
Y N CANCER
Y N CHEMICAL DEPENDENCY
Y N CHEMOTHERAPY
Y N CIRCULATORY PROBLEMS
Y N CONGENITAL HEART DISEASE - PREMED NEEDED? _____
Y N CORTISONE TREATMENTS
Y N COUGH, PERSISTANT
Y N DIABETES
Y N EPILEPSY/SEIZURES/FAINTING SPELLS
Y N EMPHYSEMA
Y N GLAUCOMA
Y N HEADACHES - FREQUENCY?
Y N HEART CONDITIONS - DESCRIBE_____
_____
_____
Y N HEMOPHILIA/ABNORMAL BLEEDING
Y N HEPATITIS - TYPE A___ B___ C___
Y N HERPES
Y N HIGH CHOLESTEROL
Y N HIV POSITIVE
Y N JOINT REPLACEMENT PREMED NEEDED?_____
_____
_____
Y N KIDNEY DISEASE
Y N LIVER DISEASE
Y N MITRAL VALVE PROLAPSE
Y N OSTEOPOROSIS
Y N PACEMAKER
Y N PSYCHIATRIC CARE
Y N RADIATION TREATMENT - COND. TREATED?_____
Y N RHEUMATIC FEVER
Y N SHINGLES
Y N SHORTNESS OF BREATH
Y N SINUS PROBLEMS
Y N STROKE - DATE?_____
Y N THYROID PROBLEMS - DESCRIBE_____
Y N TOBACCO HABIT
Y N TUBERCULOSIS
Y N ULCERS
Y N VENEREAL DISEASE

PLEASE LIST ANY SURGERIES: _____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N PENICILLIN
Y N AMOXICILLIN
Y N CLINDAMYCIN
Y N ASPRIN
Y N CODEINE
Y N DENTAL ANESTHETICS
Y N ERYTHROMYCIN
Y N TETRACYCLINE
Y N OTHER_____

WOMEN - ARE YOU PREGNANT? ❑YES ❑NO

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR HEALTH THAT WAS NOT COVERED IN THIS FORM?_____

_____

WOULD YOU LIKE TO SPEAK TO THE DOCTOR PRIVATELY ABOUT ANY HEALTH PROBLEM YOU HAVE? _____

AUTHORIZATIONS

THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES.

SIGNATURE/PARENT/GUARDIAN _____ DATE_____

I CERTIFY THAT I AM/MY MINOR/CHILD IS COVERED BY INSURANCE WITH (name of insurance company) _____
AND ASSIGN DIRECTLY TO DR. CHRISTOPHERSON ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS, WHETHER MANUAL OR ELECTRONIC.

SIGNATURE/PARENT/GUARDIAN _____ DATE_____

REVIEWED INITIALS _____ DATE_____ REVIEWED INITIALS _____ DATE_____ REVIEWED INITIALS _____ DATE_____

REVIEWED INITIALS _____ DATE_____ REVIEWED INITIALS _____ DATE_____ REVIEWED INITIALS _____ DATE_____

REVIEWED INITIALS _____ DATE_____ REVIEWED INITIALS _____ DATE_____ REVIEWED INITIALS _____ DATE_____

WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 24 HOURS ADVANCE NOTICE.