Crestridge Dental

50 McAndrews Road East
Burnsville, MN 55337
952-892-5050

WELCOME

We are committed to pursuing excellence through continuing education, personal and team growth and mastery of leading edge technology. It is our goal to hold firmly to lasting relationships we have established with our patients, while looking forward to relationships yet to be built.

PATIENT INFORMATION

Patient Name _____ **Preferred Name** _____

Address _____ **SSN** _____

City _____ **State** _____ **Zip** _____

Home (_____)_____ **Cell (_____)** _____ **Work (_____)**_____

Sex M F DOB_____ **Single Married Separated Divorced Widowed**

Patient's Employer/ School _____ **Student Status PT FT**

Email Address _____ **Occupation** _____

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

- **By providing your cellphone number or email an automatic confirmation will be sent to you.**

EMERGENCY CONTACT INFORMATION

Spouse's Name _____ **DOB** _____

Employer _____ **Sex M F**

Home (_____)_____ **Cell (_____)** _____ **Work (_____)**_____

- **In case of an emergency, who is a <u>secondary</u> contact?**

Name _____ **Relationship** _____

Home (_____)_____ **Cell (_____)** _____ **Work (_____)**_____

INSURANCE INFORMATION

Will you be using dental insurance for your visit today? Yes No

If yes, please indicate the insurance information below.

PRIMARY INSURANCE

Subscriber _____ Relationship to patient _____ DOB _____

Insurance company name _____

Employer _____ ID# _____ Group# _____

SECONDARY INSURANCE

Subscriber _____ Relationship to patient _____ DOB _____

Insurance company name _____

Employer _____ ID# _____ Group# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Crestridge Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dental office may use my health care information and may disclose such information to the above- named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____

(Signature of Patient, Parent, Guardian or Personal Representative)

Adult Medical History

Patient Name _____ D. O. B _____

Emergency Contact (Name/ Phone Number) _____

Medical History

1. Physician _____ Address _____
2. When was your last physical examination? _____
3. Are you under the care of a physician? .....Yes ◯ No ◯
   If yes, for what reason(s)? _____
4. Are you presently taking any medications/drugs/pills/herbals/supplements?..... Yes ◯ No ◯
   If yes, pleas list: _____
5. (Women) Is there a chance you are pregnant? ..... Yes ◯ No ◯
6. Do you take oral contraceptives? ..... Yes ◯ No ◯
7. Are you allergic/ sensitive to: ◯None ◯Codeine◯ Penicillin◯ Local ◯Anesthetic ◯Latex ◯Pine◯ Nuts◯ Dyes
   Other: _____
8. Do you smoke, chew or use E-cigarettes? .....Yes ◯ No ◯
   If yes, please indicate which one(s), daily frequency and how long? _____
9. Do you have Diabetes? .....Yes ◯ No ◯
   If yes, please indicate .....◯ Type 1 ◯ Type 2
   Last HbA1c date and level _____
10. Do you have, or have you ever had:

Heart trouble	Yes ◯ No◯	Excessive or prolonged bleeding	Yes◯ No◯
Heart murmur	Yes ◯ No◯	Current INR: _____	
Heart surgery	Yes ◯ No◯	Thyroid Problem	Yes◯ No◯
Heart pacemaker	Yes ◯ No◯	Jaundice	Yes◯ No◯
Rheumatic fever	Yes ◯ No◯	Hepatitis (Type)	Yes◯ No◯
Congenital heart defects	Yes ◯ No◯	Cancer	Yes◯ No◯
Artificial heart valve/stent graft	Yes ◯ No◯	Chemotherapy/ radiation	Yes◯ No◯
Abnormal blood pressure	Yes ◯ No◯	Arthritis	Yes◯ No◯
Stroke	Yes ◯ No◯	Artificial Joint Replacement	Yes◯ No◯
Ulcers/ GERD	Yes ◯ No◯	Cortico-Steroid treatment	Yes◯ No◯
Kidney trouble/ Dialysis	Yes ◯ No◯	Osteoporosis/treatment w/Bisphosphonates	Yes◯ No◯
Tuberculosis or lung disease	Yes ◯ No◯	HIV positive/ AIDS	Yes◯ No◯
Asthma	Yes ◯ No◯	Oral herpetic lesions	Yes◯ No◯
Sinus trouble	Yes ◯ No◯	Sexually Transmitted disease	Yes◯ No◯
Epilepsy/ seizures	Yes ◯ No◯	Psychiatric care	Yes◯ No◯
Fainting spells	Yes ◯ No◯	Glaucoma	Yes◯ No◯
Anemia	Yes ◯ No◯	Hearing Impaired	Yes◯ No◯
Leukemia	Yes ◯ No◯	Chemical dependency	Yes◯ No◯
		Do you take pre-medication?	Yes◯ No◯
		If yes, for what reason (s)? _____	

11. Have you had any other serious illness, hospitalization or accident?
    If yes, please explain: _____

Height: _____ Weight: _____

OVER ➡