



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 secondary 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.

Court fees and 1.5% monthly interest charges will be applied to any delinquent accounts.

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

Adult Medical History

Patient Name _____ D. O. B _____

Emergency Contact (Name/ Phone Number) _____

Medical History

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

Height: _____ Weight: _____

OVER 