



Dr. Karl Berg / Dr. Michael Skramstad
2765 Kelley Parkway, Suite 140
Orono, MN 55356
PH: 952.449.9494 / Fax: 952.449.9499
www.oronodentalcare.com

NEW PATIENT INFORMATION FORM

NAME (LAST, FIRST, MIDDLE):

PREFERRED NAME:

HOME ADDRESS:

CELL PHONE: HOME PHONE: WORK PHONE:

EMAIL: SS#:

DOB: SEX: MARITAL STATUS:

EMPLOYER NAME:

REFERRING PATIENT OR DOCTOR:

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME:

RELATION TO PATIENT: SS# DOB:

EMPLOYER NAME:

INSURANCE COMPANY: GROUP #:

INSURANCE COMPANY ADDRESS:

FAMILY YEARLY DEDUCTIBLE: INDIV YEARLY DEDUCTIBLE:

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME:

RELATION TO PATIENT: SS# DOB:

EMPLOYER NAME:

INSURANCE COMPANY: GROUP #:

INSURANCE COMPANY ADDRESS:

FAMILY YEARLY DEDUCTIBLE: INDIV YEARLY DEDUCTIBLE:

Thank You!

# PATIENT HEALTH RECORD

(Please complete both sides)

Date \_\_\_\_\_

It is important to tell all dental personnel involved in your treatment about the general state of your health. This information is, of course, confidential.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

## MEDICAL HISTORY

1. Name and address of physician \_\_\_\_\_
2. When was your last physical examination? \_\_\_\_\_
3. Are you now under the care of a physician? Yes  No  If yes, for what reason? \_\_\_\_\_

4. Are you presently taking any medications/drugs/pills? Yes  No  Please list name of medication, amount/day, reason for taking \_\_\_\_\_

5. Do you smoke or use tobacco? Yes  No  If yes, how much/day \_\_\_\_\_

6. (Women) Are you pregnant? Yes  No  If yes, how long? \_\_\_\_\_

7. Are you allergic to: Penicillin, Codeine, Local Anesthetic, Latex, Other \_\_\_\_\_

8. Have you ever been required to take antibiotics before dental treatment? Yes  No

9. Do you have, or have you ever had:
- |   |  |                                       |  |  |
|---|--|---------------------------------------|--|--|
| Arthritis .....                         |  |                                       |  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Trouble .....                     | Yes <input type="checkbox"/> No <input type="checkbox"/> | Excessive or prolonged bleeding ..... | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart murmur or defect .....            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Fainting spells .....                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart surgery .....                     | Yes <input type="checkbox"/> No <input type="checkbox"/> | Jaundice .....                        | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart pacemaker .....                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hepatitis — Type: _____ .....         | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Rheumatic fever .....                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Asthma or hay fever .....             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Congenital heart defects .....          | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sinus trouble .....                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Abnormal blood pressure .....           | Yes <input type="checkbox"/> No <input type="checkbox"/> | Cancer .....                          | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Ulcers .....                            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Chemotherapy/radiation .....          | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Tuberculosis or lung disease .....      | Yes <input type="checkbox"/> No <input type="checkbox"/> | Stroke .....                          | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diabetes .....                          | Yes <input type="checkbox"/> No <input type="checkbox"/> | Glaucoma .....                        | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Epilepsy .....                          | Yes <input type="checkbox"/> No <input type="checkbox"/> | Psychiatric care .....                | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Anemia .....                            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Prosthetic implant .....              | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Thyroid problem .....                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Venereal disease .....                | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chemical/Alcohol dependency .....       | Yes <input type="checkbox"/> No <input type="checkbox"/> | HIV positive/AIDS/ARC .....           | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| History of bacterial endocarditis ..... | Yes <input type="checkbox"/> No <input type="checkbox"/> | Joint replacement .....               | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

10. Have you had any other serious illness, hospitalization or accident: Yes  No   
 If yes, please explain \_\_\_\_\_

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Patient, Parent, or Guardian

\_\_\_\_\_ Signature of Dentist

UPDATE _____  D.D.S. Initials _____	UPDATE _____  D.D.S. Initials _____
UPDATE _____  D.D.S. Initials _____	UPDATE _____  D.D.S. Initials _____
UPDATE _____  D.D.S. Initials _____	UPDATE _____  D.D.S. Initials _____

## DENTAL HISTORY

1. Former dentist \_\_\_\_\_ Address \_\_\_\_\_
2. When did you last visit a dentist? \_\_\_\_\_ Dental Films taken?  Yes  No  
What was done at that time? \_\_\_\_\_  
Why did you leave that practice? \_\_\_\_\_  
Did you make regular visits to the dentist before then?  Yes  No
3. Are you aware of a dental problem?  Yes  No  
Explain \_\_\_\_\_
4. Does dental treatment make you nervous?  slightly  moderately  extremely  No\*
5. What do you feel is the present condition of your mouth? \_\_\_\_\_
6. Have you ever had difficulty opening or closing jaw, clicking, popping?  Yes  No
7. Do your gums bleed?  Yes  No
8. Have you ever been told you have gum disease?  Yes  No
9. Does food chronically collect between your teeth?  Yes  No
10. Are your teeth acutely sensitive to: Sweet  Cold  Heat  Pressure  Biting
11. How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_
12. Do you have swelling, lump or sore in your mouth?  Yes  No
13. Are you bothered with unpleasant taste or bad breath?  Yes  No
14. Has any dental treatment been recommended to you that you have not had done?  Yes  No  
Explain \_\_\_\_\_
15. Are you happy with the appearance of your smile?  Yes  No  
Would you like to have straighter teeth?  Yes  No  
Would you like to have whiter teeth?  Yes  No
16. Do you clench or grind your teeth?  Yes  No
17. Have you worn a bite splint and/or had your bite adjusted?  Yes  No
18. Have you ever had orthodontics?  Yes  No
19. Have you had oral surgery? If so what \_\_\_\_\_
20. Anything else that would be valuable for me to know? \_\_\_\_\_
21. Whom may we thank for referring you to our office? \_\_\_\_\_

## INSURANCE

- As a courtesy to you, we will submit an insurance claim for all treatment the day treatment is completed. In order to provide this service to you, we must have complete insurance information, including policyholder's name, group number and an address for where to send the claim.
- Your coverage will be determined by the limitations of your policy. We do not accept responsibility for negotiating claims.
- Insurance coverage is an agreement between you and your insurance carrier. Therefore, you will still receive a statement from us although a claim has been submitted. Insurance coverage does not dismiss you of the account balance.
- Any overpayment we receive from the insurance company however, will be refunded to you.

## CONSENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connections with (Name of Patient) \_\_\_\_\_ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand that use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2 compound interest (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_



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REQUEST FOR RELEASE OF PATIENT RECORDS

Please mail or fax this release form to your previous dental office prior to your upcoming dental appointment. This will allow them time to forward your x-rays in time for your office visit. Please complete and sign the top section before forwarding to your previous office. Thank you.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Additional family members (if necessary):

\_\_\_\_\_, DOB: \_\_\_\_\_
\_\_\_\_\_, DOB: \_\_\_\_\_
\_\_\_\_\_, DOB: \_\_\_\_\_
\_\_\_\_\_, DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_
(of Patient, Parent, or Guardian)

\*\*\*\*\*To Be Completed By Previous Dentist\*\*\*\*\*

Patient of Record since: \_\_\_\_\_ Last Appointment: \_\_\_\_\_
Routine Maintenance: YES/NO Sealants: YES/NO
General Operative: YES/NO Orthodontic: YES/NO
Periodontal: YES/NO Prosthetic: YES/NO
Oral Surgery: YES/NO Endodontic: YES/NO
Emergency/Infrequent Treatment: YES/NO
Incomplete treatment: \_\_\_\_\_

Enclosures:

BWX 2/4 Dated: \_\_\_\_\_ Panorex Dated: \_\_\_\_\_
FMX Dated: \_\_\_\_\_ Flouride Tx Dated: \_\_\_\_\_

Please mail any records to: Orono Dental Care
2765 Kelley Parkway, Suite 140
Orono, MN 55356
952.449.9494/ Fax: 952.449.9499

OR Fax this sheet to 952.449.9499 and email records to: xray@oronodentalcare.com

If there are no current records, please indicate so and fax this form to 952-449-9499. Thank you!



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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

You may obtain a copy of our Notice of Privacy Practices, including revisions of our Notice, at any time by contacting:

Contact Person: Judi Grygar
Address: 2765 Kelley Parkway, Suite 140
Orono, MN 55356
Telephone: 952.449.9494

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

PRINT NAME BELOW:

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT