

1870 W. Wayzata Blvd
PO Box 695
Long Lake, MN 55356



Ph: 952-473-7151
Fax: 952-475-1539
longlakedental@uslink.net

Patient Information

Name: _____ Date: ____/____/____
Last, First, Middle Initial

Date of birth: ____/____/____ Person Responsible for the Account: _____

Address: _____

City, State, Zip: _____ Relationship to Patient (Please Circle):
Self Spouse Child Other _____

Home Phone: (____) ____ - _____

Cell Phone: (____) ____ - _____

Work Phone: (____) ____ - _____ Employed by: _____

Email Address: _____ Occupation: _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

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

Dental History

Date of Last Dental Exam: _____

Chief Dental Complaint: _____

Do you have or Have You Had Any of the Following? (Please Circle All That Apply)

- | | |
|--|---|
| Sensitivity to hot, cold, sweets or pressure | Negative Dental Experiences |
| Clicking or popping noise when opening mouth | Pain In or Near Ears |
| Food packing | Swelling or Lumps in Mouth |
| Orthodontic Treatment | Missing Teeth Not Replaced |
| Broken Fillings | Wisdom Teeth Extracted |
| Periodontal Treatment | Other Teeth Extracted |
| Clenching or Grinding | Prolonged Bleeding Following Extraction |

Medical History

Physicians Name: _____ Women: Are you Pregnant? Yes No

Date of Last Medical Examination _____ Due Date: _____

Do You Have or Have You Had Any of the Following? (Please Circle All That Apply)

- | | | |
|--------------------------------|-----------------------------|--------------------------|
| Allergies to Drugs/Anesthetics | Sinus Problems | Psychiatric Care |
| Asthma | High Blood Pressure | Tuberculosis |
| Joint Replacement | Liver Problems or Hepatitis | Anemia or blood problems |
| Diabetes | Stroke | Emotional Problems |
| Pacemaker | Neurologic Problems | Ulcers or Colitis |
| Artificial Heart Valve | Malignancies | Arthritis |
| Heart Ailments | Cataracts | AIDS |
| Kidney Problems | Radiation Treatment | Rheumatic Fever |

1870 W. Wayzata Blvd
PO Box 695
Long Lake, MN 55356



Ph: 952-473-7151
Fax: 952-475-1539
longlakedental@uslink.net

Insurance Information

Subscriber Name: _____ Subscriber Date of birth: ____/____/____
Patient Relationship to Subscriber (Please Circle): Self Spouse Child Other: _____
Name of Insurance Company: _____ Group #: _____
Claims Address for Insurance Company: _____
Subscriber Social Security number: ____ - ____ - ____ Subscriber ID Number: _____
Employer Name: _____
Employer Address: _____

Secondary Insurance

Do you have another Dental Policy? Yes No
Subscriber Name: _____ Subscriber Date of birth: ____/____/____
Patient Relationship to Subscriber (Please Circle): Self Spouse Child Other: _____
Name of Insurance Company: _____ Group #: _____
Claims Address for Insurance Company: _____
Subscriber Social Security number: ____ - ____ - ____ Subscriber ID Number: _____
Employer Name: _____
Employer Address: _____

Insurance Signature on File

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed this particular claim.

Patient/Guardian Signature _____ Date _____