PARKWAY
DENTAL CENTER
4701 Nicollet Avenue
Minneapolis, MN 55419
612.824.4211
www.allbeautifulsmiles.com

PATIENT REGISTRATION FORM

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

GETTING TO KNOW YOU

PATIENT NAME:

_____
LAST FIRST MIDDLE

BIRTHDATE:____/____/____ AGE:_____ SSN:_____

HOME ADDRESS:_____
STREET

_____
CITY STATE ZIP

CELL PHONE:_____ WORK PHONE:_____

HOME PHONE:_____

E-MAIL:_____

I PREFER TO BE CONTACTED BY:
☐ CELL ☐ WORK ☐ HOME ☐ E-MAIL

EMPLOYER:_____OCCUPATION:_____

SPOUSE NAME:_____

PARENT/GUARDIAN NAME:

_____
LAST FIRST

EMERGENCY CONTACT NAME:_____

RELATIONSHIP:_____

CELL/WORK/HOME PHONE:_____

PLEASE TELL US HOW YOU HEARD ABOUT OUR OFFICE:

_____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

INSURANCE COMPANY:_____

CLAIMS ADDRESS:_____

_____

INSURANCE COMPANY PHONE:_____

GROUP/POLICY NUMBER:_____

SUBSCRIBER NAME:_____

SUBSCRIBER BIRTHDATE:_____/_____/_____

SUBSCRIBER ID#/SSN:_____

SUBSCRIBER EMPLOYER:_____

RELATION TO PATIENT:_____

ACKNOWLEDGMENT

I certify that I (or my dependent) have insurance coverage with the above named insurance company and assign directly to Parkway Dental Center all insurance benefits. I understand that I am financially responsible for all charges: any deductible amount, co-insurance, or any balance not paid for by my insurance company. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE:

_____

PRINTED NAME:

_____

PLEASE FILL IN COMPLETELY

DENTAL HISTORY

Reason for Today's Visit:_____

Former Dental/Clinic Name:_____

Date of last dental visit:_____

MEDICAL HISTORY

Your Physician/Clinic name:_____

Clinic phone:_____ Date of last visit:_____

Is there any Medical or Dental information you feel we should know about?
☐ Yes, please explain_____ ☐ No

DO YOU HAVE, OR EVER HAD, ANY OF THE FOLLOWING? PLEASE MARK YES OR NO TO EACH CONDITION

Bad Breath ☐Yes ☐No
Bleeding gums ☐Yes ☐No
Blisters on lips or mouth ☐Yes ☐No
Burning sensation on tongue ☐Yes ☐No
Cigarette, pipe, or cigar smoking ☐Yes ☐ No
Clicking or popping jaw ☐Yes ☐No
Dry mouth ☐Yes ☐ No
Food collection between your teeth ☐Yes ☐No
Grinding teeth ☐Yes ☐No
Gums swollen or tender ☐Yes ☐No
Jaw pain or tiredness ☐Yes ☐No
Lip or cheek biting ☐Yes ☐No
Loose teeth or broken fillings ☐Yes ☐No
Mouth breathing ☐Yes ☐No
Mouth pain when brushing ☐Yes ☐No
Orthodontic treatment (braces) ☐Yes ☐ No
Periodontal treatment ☐Yes ☐No
Sores or growth in your mouth ☐Yes ☐No
Sensitivity to (if yes, please circle):
Cold, heat, sweets, when chewing
Do you regularly brush? ☐Yes ☐No
Do you regularly use floss? ☐Yes ☐No

Acid Reflux ☐Yes ☐No
Arthritis ☐Yes ☐No
Abnormal bleeding ☐Yes ☐No
AIDS/HIV Positive ☐Yes ☐No
Anemia ☐Yes ☐No
Artificial Joints ☐Yes ☐No
Type_____ Year_____
Artificial Heart Valve ☐Yes ☐No
Asperger/Autism ☐Yes ☐No
Asthma ☐Yes ☐No
Back Problems ☐Yes ☐No
Cancer ☐Yes ☐No
Type_____ Year_____
Chemical Dependency ☐Yes ☐No
Chemotherapy ☐Yes ☐No
Year_____
Circulatory Problems ☐Yes ☐No
Cough ☐Yes ☐No
Diabetes Type___ ☐Yes ☐No
Emphysema/COPD ☐Yes ☐No
Epilepsy ☐Yes ☐No
Fainting/Dizziness ☐Yes ☐No
Feet/Ankle Swelling ☐Yes ☐No
Head/Neck Growth ☐Yes ☐No
Headaches ☐Yes ☐No
Heart Disease ☐Yes ☐No
Hemophilia ☐Yes ☐No

Hepatitis Type___ ☐Yes ☐No
Herpes ☐Yes ☐No
HPV ☐Yes ☐No
High Blood Pressure ☐Yes ☐No
High Cholesterol ☐Yes ☐No
Kidney Disease ☐Yes ☐No
Liver Disease ☐Yes ☐No
Low Blood Pressure ☐Yes ☐No
Neck Pain ☐Yes ☐No
Pacemaker ☐Yes ☐No
Psychiatric Care ☐Yes ☐No
Radiation Treatment ☐Yes ☐No
Respiratory Disease ☐Yes ☐No
Shortness of Breath ☐Yes ☐No
Sjogren's Syndrome ☐Yes ☐No
Sinus Trouble ☐Yes ☐No
Skin Rash ☐Yes ☐No
Special Diet ☐Yes ☐No
Stroke ☐Yes ☐No
Swollen Glands ☐Yes ☐No
Thyroid Problems ☐Yes ☐No
Tuberculosis ☐Yes ☐No
Ulcer ☐Yes ☐No
Venereal Disease ☐Yes ☐No
Women:
Are you nursing? ☐Yes ☐No
Pregnant? Due Date_____ ☐No

ALLERGIES

☐ Amoxicillin
☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Erythromycin
☐ Iodine
☐ Local Anesthetic
☐ **LATEX**
☐ Nuts
☐ Penicillin
☐ Sulfa
☐ Other: _____
☐ None Known

MEDICATIONS

Please list all current medications (prescribed & over the counter)

_____
_____
_____
_____

Pharmacy & Number_____

AUTHORIZATION AND CONSENT

I confirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in strictest confidence and it is my responsibility to inform the office of any changes. I hereby authorize the Doctor to take x-rays, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform dental treatment, medication, and therapy that may be indicated. I also understand that all dental procedures and the use of anesthetic agents carry a certain risk.

PRINTED NAME:_____**DATE:**_____

SIGNATURE:_____**CONSENT (if child/minor)**_____ I hereby authorize the necessary dental treatment to be performed for the child/minor named above.

DOCTOR ONLY

BP PULSE