Northpark Dental

9120 Baltimore Street NE – Blaine, MN 55449
(763) 786-1560
www.northparkdentalcare.com

Patient Information

Today's Date:_____
Last Name:_____First Name:_____Middle:_____
Date of Birth:_____Social Security Number:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Email Address: _____
Home Phone:_____Mobile Phone:_____
Employer:_____ Occupation:_____
Employer Phone:_____ Years Employed There:_____
How did you hear about Northpark Dental?_____

Emergency Contact

Name:_____Phone Number:_____Relationship to Patient:_____

Responsible Party Information

Please note – if information is the same as above, you may skip this section

Last Name:_____First Name:_____Middle:_____
Date of Birth:_____Social Security Number:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Email Address: _____
Home Phone:_____Mobile Phone:_____
Employer:_____ Occupation:_____
Employer Phone:_____Years Employed There:_____

Insurance Information

Primary Insurance

Policyholder's Name:_____Relationship to Patient:_____
Date of Birth:_____Social Security Number:_____
Employer:_____Insurance Company: _____
Group Number: _____Subscriber ID: _____
Claim Address:_____

Secondary Insurance

Please note - if you are covered under another plan please fill out this section

Policyholder's Name:_____Relationship to Patient:_____
Date of Birth:_____Social Security Number:_____
Employer:_____Insurance Company: _____
Group Number: _____Subscriber ID: _____
Claim Address:_____

-Please Continue to Back Side of This Form-

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Patient Health History

Patient name:_____ Date of Birth:_____
Physician / Clinic:_____ Clinic Phone:_____
Former / Previous Dentist:_____

1. Have you had a complete dental examination in the past three years? Yes / No
2. Do you brush / floss regularly? Yes / No
3. Do you smoke? Yes / No
   If yes, how many packs a day? _____
4. Have you had any unfavorable reactions from dental treatment? Yes / No
   If yes, please explain:_____
5. Are you presently under the care of a physician? Yes / No
   If yes, please explain:_____
6. Are you taking any medication? Yes / No
   If so, please list: _____
   _____
7. Have you had any serious illness or surgery in the past? Yes / No
   If yes, please explain:_____
8. Are you allergic to any medications? Yes / No
   If so, please list:_____
9. Are you allergic to latex? Yes / No
10. Are you pregnant? Yes / No
11. Have you had a heart attack in the last six months? Yes / No
12. Do you have or have you ever had:

AIDS / HIV	Yes / No	Drug / Chemical Dependency	Yes / No
Anemia	Yes / No	Epilepsy	Yes / No
Asthma	Yes / No	Heart Murmur	Yes / No
Artificial Heart Valve	Yes / No	Heart Trouble	Yes / No
Artificial Joint Replacement	Yes / No	Hepatitis	Yes / No
Bleeding Problems	Yes / No	High Blood Pressure	Yes / No
Cancer	Yes / No	Jaundice	Yes / No
Chemotherapy / Radiation Treatments	Yes / No	Rheumatic Fever	Yes / No
Congenital Heart Disease	Yes / No	Thyroid Disease	Yes / No
Diabetes	Yes / No	Tuberculosis	Yes / No

Consent: I give my consent to any advisable and necessary dental procedures, medicines, or anesthetics to be administered by the doctor/supervised staff for diagnostic purposes or dental treatment.

Signature:_____ Date:_____

Relationship to Patient (*if a minor*): _____

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Financing: I understand I am financially responsible for the services provided for myself or for the above named patient regardless of insurance coverage. I also understand any insurance follow-up is my responsibility. A service charge of .66% (8% annually) will be charged on all accounts over 60 days. I also understand I am responsible for any collection fees added to this account should this account be turned over to a collection agency.

Authorization: I authorize Northpark Dental to release information to other medical parties for medical or dental use only.

Signature:_____ _____ Date:_____

Relationship to Patient (*if a minor*): _____