Grove Dentist

13649 Grove Drive, Maple Grove, MN 55311 • Phone:763-420-8038 • Fax:763-494-4222

Patient Information / Adult

The following confidential information is important for the dentist to know in planning your dental care. Please answer each question as completely as you can. Thank you.

Patient Name:		Today's Date:	
Address:		Home Phone #	
City, State, Zip:		Work Phone #	
Social Security #	Drivers License #	Date of Birth	Marital Status:
Employer:		How Long?	Occupation:
Spouse's Name:		Work Phone#	
Spouse's Employer:		How Long?	Occupation:

Name, Relation and Phone Number of person to contact in case of emergency:

Referred By: ☐ Insurance ☐ Online ☐ Signage ☐ Patient ☐ Local Newspaper/Money Mailer

Account Information

Person Responsible for Account (if different from above):	Relationship to Above:	
Address:	Home Phone#	Work Phone#
City, State, Zip:	Date of Birth:	Social Security #

Dental Insurance information

Primary Dental Insurance Company Name:	Group#
Insurance Company Address:	Telephone #
Insured's Name:	Relationship:
Insured's Employer	Insured's SS#
Secondary Dental Insurance Company Name:	Group #
Insurance Company Address:	Telephone #
Insured's Name:	Relation:
Insured's Employer	Insured's SS#
Medical Assistance / Minnesota Care	MemberID #

Health Information - Dental

Previous Dentist:	**Do any of the following apply to you?**				
	Toothache	☐ yes ☐ no		Mouth sores	☐ yes ☐ no
Reason for today's visit or specific concern:	Cold sensitivity	☐ yes ☐ no		Swelling in mouth	☐ yes ☐ no
	Heat sensitivity	☐ yes ☐ no		Unpleasant taste	☐ yes ☐ no
Do you like your smile? What would you change?	Pressure sensitivity	☐ yes ☐ no		Teeth stains	☐ yes ☐ no
	Sweet sensitivity	☐ yes ☐ no		Grinding/Clenching	☐ yes ☐ no
Last dental checkup:	Bleeding Gums	☐ yes ☐ no		Jaw joint noise	☐ yes ☐ no
	Gums hurt	☐ yes ☐ no		History of locked jaw	☐ yes ☐ no
Last X-rays taken:	History of gum treatment	☐ yes ☐ no		History of improper bite	☐ yes ☐ no
	Loose teeth	☐ yes ☐ no		History of braces	☐ yes ☐ no
Are you interested in regular dental care?	Bad breath	☐ yes ☐ no		Food collects	☐ yes ☐ no
How often do you brush your teeth?					
How often do you floss your teeth?					

Health Information - Medical

Physicians Name:	**Are you allergic to:**				
	Penicillin	☐ yes ☐ no		Local Anesthetic	☐ yes ☐ no
Phone#	Codeine	☐ yes ☐ no		Latex	☐ yes ☐ no
	Other				
Are you presently under the care of a physician?					
If yes, please explain:	List all medications or drugs (and dosages) that you are taking:				
Have you ever had a serious illness or accident?					
If yes, please explain:					
(Women) Are you pregnant?					
If yes, how long:					

Do any of the following apply to you now or in the past?

Use tobacco	☐ yes ☐ no	Ulcers	☐ yes ☐ no	Chemical dependency	☐ yes ☐ no
Rheumatic fever	☐ yes ☐ no	Diabetes	☐ yes ☐ no	Mental health care	☐ yes ☐ no
Heart attack	☐ yes ☐ no	Hemophilia/abnormal bleeding	☐ yes ☐ no	Tumors/cancer	☐ yes ☐ no
Congenital heart defect	☐ yes ☐ no	Anemia	☐ yes ☐ no	Glaucoma	☐ yes ☐ no
Abnormal blood pressures	☐ yes ☐ no	Tuberculosis, Lung Disease	☐ yes ☐ no	Radiation therapy	☐ yes ☐ no
Stroke	☐ yes ☐ no	Asthma, hay fever	☐ yes ☐ no	Joint replacement or implant	☐ yes ☐ no
Heart murmur	☐ yes ☐ no	Epilepsy, convulsions	☐ yes ☐ no	Venereal disease	☐ yes ☐ no
Thyroid problem	☐ yes ☐ no	Hay fever, sinus problems	☐ yes ☐ no	Arthritis	☐ yes ☐ no
HIV positive/AIDS	☐ yes ☐ no	Artificial heart valve		Other	☐ yes ☐ no
Hepatitus A B C	☐ yes ☐ no	Mitral valve prolapse	☐ yes ☐ no		

The above information is correct to the best of my knowledge. I authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as many be necessary for proper dental care.

Patient Signature: _____ **Date:** _____

D.D.S. Signature: _____ **Date:** _____