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.

		loday's Date:				
Address:		Home Phone # Work Phone #				
City, State, Zip:						
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	of person to contact in case of emergency:					
Referred By: ☐ Insurance ☐ Onlin	e □ Signage □ Patient □ Local Ne	wspaper/Money Mailer				
	Account Info	ormation				
Person Responsible for Account (if different from above):		Relationship to Above				
Address:	Taxon 1	Home Phone#	Work Phone#			
		Home Phone# Date of Birth:	Work Phone# Social Security #			
Address:						
Address:	Dental Insurance	Date of Birth:				
Address:	tendence by	Date of Birth:				
Address: City, State, Zip:	tendence by	Date of Birth:				
Address: City, State, Zip: Primary Dental Insurance Company	tendence by	Date of Birth: e information Group#				
Address: City, State, Zip: Primary Dental Insurance Company Insurance Company Address:	tendence by	Date of Birth: e information Group# Telephone #				
Address: City, State, Zip: Primary Dental Insurance Company Insurance Company Address: Insured's Name:	Name:	Date of Birth: e information Group# Telephone # Relationship:				
Address: City, State, Zip: Primary Dental Insurance Company Insurance Company Address: Insured's Name: Insured's Employer	Name:	Date of Birth: e information Group# Telephone # Relationship: Insured's SS#				
Address: City, State, Zip: Primary Dental Insurance Company Insurance Company Address: Insured's Name: Insured's Employer Secondary Dental Insurance Company	Name:	Date of Birth: Peinformation Group# Telephone # Relationship: Insured's SS# Group #				
Address: City, State, Zip: Primary Dental Insurance Company Insurance Company Address: Insured's Name: Insured's Employer Secondary Dental Insurance Compan Insurance Company Address:	Name:	Date of Birth: e information Group# Telephone # Relationship: Insured's SS# Group # Telephone #				

Health Information - Dental

Previous Dentist:		The same of the sa		AND DESCRIPTION OF THE PERSON NAMED IN	THE RESERVE AND ADDRESS OF THE PERSON NAMED IN		THE RESERVE THE PERSON NAMED IN	_	
		Do a	ny of the	following appl	y to you?				
		Tooth	nache	□ ye	s 🗆 no	Mouth sores		yes	□ no
Reason for today's visit or specific concern:		Cold	sensitivity	□ ye	s 🗆 no	Swelling in mouth		yes	□no
		Heat	sensitivity	□ ye	s 🗆 no	Unpleasant taste		yes	□ no
Do you like your smile? Wha	at would you change?	Press	ure sensitiv	rity □ ye	s 🗆 no	Teeth stains		yes	□ no
		Sweet	sensitivity	□ ye	s 🗆 no	Grinding/Clenchin	g 🗆	yes	□ no
Last dental checkup:		Bleed	ing Gums	□ ye	s 🗆 no	Jaw joint noise		yes	□ no
		Gums	s hurt	□ ye	s 🗆 no	History of locked ja	aw 🗆	yes	□no
Last X-rays taken:		Histo	ry of gum t	reatment ye	s 🗆 no	History of imprope	r bite 🗆	yes	□ no
		Loose	e teeth	□ ye	s 🗆 no	History of braces		yes	□ n
Are you interested in regular of	dental care?	Bad b	reath	□ ye	s 🗆 no	Food collects		yes	□ n
How often do you brush your	teeth?					ACCOUNT OF THE STATE OF		W. W. L.	
How often do you floss your to									
		Hoolth Informat	tion	Modia	_1				
		Health Informa			aı			The	
Physicians Name:			ou allerg						
		Penic			s 🗆 no	Local Anesthetic		yes	□ no
Phone#		Code	Marine Tolkins	□ уе	s 🗆 no	Latex		yes	□ no
		Other							
Are you presently under the ca	are of a physician?								
If yes, please explain:		List a	ll medication	ons or drugs (and	dosages) t	hat you are taking:			
Have you ever had a serious il	lness or accident?			***					
If yes, please explain:						and the second			
If yes, please explain: (Women) Are you pregnant?									
				4					
(Women) Are you pregnant?			in the last	A A					
(Women) Are you pregnant? If yes, how long:	g apply to you now	or in the past?							
(Women) Are you pregnant?		or in the past? Ulcers	□yes	no	Chemica	l dependency	□ yes		10
(Women) Are you pregnant? If yes, how long: Do any of the following	□ yes □ no		□ yes			l dependency ealth care			
(Women) Are you pregnant? If yes, how long: Do any of the following Use tobacco Rheumatic fever	□ yes □ no	Ulcers Diabetes	□ yes	□ no	Mental h	ealth care	□ yes	□r	10
(Women) Are you pregnant? If yes, how long: Do any of the following Use tobacco Rheumatic fever Heart attack	□ yes □ no □ yes □ no □ yes □ no	Ulcers Diabetes Hemophilia/abnormal bleedir	□ yes	□ no	Mental h Tumors/o	ealth care cancer	□ yes		10
(Women) Are you pregnant? If yes, how long: Do any of the following Use tobacco Rheumatic fever Heart attack Congenital heart defect	□ yes □ no	Ulcers Diabetes Hemophilia/abnormal bleedir Anemia	□ yes □ yes □ yes	□ no □ no □ no	Mental h Tumors/o Glaucom	ealth care cancer a	☐ yes ☐ yes ☐ yes		10
(Women) Are you pregnant? If yes, how long: Do any of the following Use tobacco Rheumatic fever Heart attack Congenital heart defect Abnormal blood pressures	□ yes □ no	Ulcers Diabetes Hemophilia/abnormal bleedir Anemia Tuberculosis, Lung Disease	□ yes ng □ yes □ yes □ yes	no no no no	Mental h Tumors/o Glaucom Radiation	ealth care cancer a n therapy	□ yes □ yes □ yes □ yes		10
(Women) Are you pregnant? If yes, how long: Do any of the following Use tobacco Rheumatic fever Heart attack Congenital heart defect Abnormal blood pressures Stroke	yes	Ulcers Diabetes Hemophilia/abnormal bleedir Anemia Tuberculosis, Lung Disease Asthma, hay fever	□ yes □ yes □ yes □ yes □ yes □ yes	□ no □ no □ no □ no □ no	Mental h Tumors/o Glaucom Radiation Joint repl	ealth care cancer a n therapy acement or implant	 yes yes yes yes yes 		10 10 10 10 10
(Women) Are you pregnant? If yes, how long: Do any of the following Use tobacco Rheumatic fever Heart attack Congenital heart defect Abnormal blood pressures Stroke Heart murmur	yes	Ulcers Diabetes Hemophilia/abnormal bleedir Anemia Tuberculosis, Lung Disease Asthma, hay fever Epilepsy, convulsions	gyes gyes gyes gyes gyes gyes gyes gyes	no	Mental h Tumors/o Glaucom Radiation Joint repl Venereal	ealth care cancer a therapy acement or implant disease	 yes yes yes yes yes yes 		10 10 10 10 10 10
(Women) Are you pregnant? If yes, how long: Do any of the following Use tobacco Rheumatic fever Heart attack Congenital heart defect Abnormal blood pressures Stroke Heart murmur Thyroid problem	yes	Ulcers Diabetes Hemophilia/abnormal bleedir Anemia Tuberculosis, Lung Disease Asthma, hay fever Epilepsy, convulsions Hay fever, sinus problems	gyes gyes gyes gyes gyes gyes gyes gyes	□ no □ no □ no □ no □ no	Mental h Tumors/o Glaucom Radiation Joint repl Venereal Arthritis	ealth care cancer a therapy acement or implant disease	yes		10 10 10 10 10 10 10
(Women) Are you pregnant? If yes, how long: Do any of the following Use tobacco Rheumatic fever Heart attack Congenital heart defect Abnormal blood pressures Stroke Heart murmur Thyroid problem HIV positive/AIDS	yes	Ulcers Diabetes Hemophilia/abnormal bleedir Anemia Tuberculosis, Lung Disease Asthma, hay fever Epilepsy, convulsions Hay fever, sinus problems Artificial heart valve	g yes g yes yes yes yes yes yes yes yes	no	Mental h Tumors/o Glaucom Radiation Joint repl Venereal	ealth care cancer a therapy acement or implant disease	 yes yes yes yes yes yes 		10 10 10 10 10 10 10
(Women) Are you pregnant? If yes, how long: Do any of the following Use tobacco Rheumatic fever Heart attack Congenital heart defect Abnormal blood pressures Stroke Heart murmur Thyroid problem HIV positive/AIDS	yes	Ulcers Diabetes Hemophilia/abnormal bleedir Anemia Tuberculosis, Lung Disease Asthma, hay fever Epilepsy, convulsions Hay fever, sinus problems	g yes g yes yes yes yes yes yes yes yes	no	Mental h Tumors/o Glaucom Radiation Joint repl Venereal Arthritis	ealth care cancer a therapy acement or implant disease	yes		10 10 10 10 10 10 10
(Women) Are you pregnant? If yes, how long: Do any of the following Use tobacco Rheumatic fever Heart attack Congenital heart defect Abnormal blood pressures Stroke Heart murmur Thyroid problem HIV positive/AIDS Hepatitus A B C	yes	Ulcers Diabetes Hemophilia/abnormal bleedir Anemia Tuberculosis, Lung Disease Asthma, hay fever Epilepsy, convulsions Hay fever, sinus problems Artificial heart valve	g yes g yes yes yes yes yes yes yes yes	no	Mental h Tumors/o Glaucom Radiation Joint repl Venereal Arthritis Other	ealth care cancer a n therapy acement or implant disease	yes yes yes yes yes yes yes yes yes		10 10 10 10 10 10 10 10
(Women) Are you pregnant? If yes, how long: Do any of the following Use tobacco Rheumatic fever Heart attack Congenital heart defect Abnormal blood pressures Stroke Heart murmur Thyroid problem HIV positive/AIDS Hepatitus A B C The above information	yes	Ulcers Diabetes Hemophilia/abnormal bleedir Anemia Tuberculosis, Lung Disease Asthma, hay fever Epilepsy, convulsions Hay fever, sinus problems Artificial heart valve Mitral valve prolapse	g yes g yes yes yes yes yes yes yes yes yes	no no no no no no no no no	Mental h Tumors/o Glaucom Radiation Joint repl Venereal Arthritis Other	ealth care cancer a n therapy acement or implant disease	yes yes yes yes yes yes yes yes yes		10 10 10 10 10 10 10 10
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(Women) Are you pregnant? If yes, how long: Do any of the following Use tobacco Rheumatic fever Heart attack Congenital heart defect Abnormal blood pressures Stroke Heart murmur Thyroid problem HIV positive/AIDS Hepatitus A B C The above information	yes no	Ulcers Diabetes Hemophilia/abnormal bleedir Anemia Tuberculosis, Lung Disease Asthma, hay fever Epilepsy, convulsions Hay fever, sinus problems Artificial heart valve Mitral valve prolapse st of my knowledge. I authories as many be necessary for pro-	g yes g yes yes yes yes yes yes yes yes yes	no no no no no no no no no	Mental h Tumors/o Glaucom Radiation Joint repl Venereal Arthritis Other	ealth care cancer a n therapy acement or implant disease nedications and pe	yes yes yes yes yes yes yes yes yes		10 10 10 10 10 10 10 10