Instructions

Completion Instructions:

1. **If completing this form by hand:**
    a. Print a copy on your home or office printer
    b. Fill-out as much information as possible
    c. Sign and bring to your scheduled appointment, or
    d. Mail to: West Range Dental Care | 1043 East Hwy. 169 | Grand Rapids, MN 55744

2. **To complete and submit this form electronically:**
    a. Please fill-out on your computer or mobile device
    b. Save it to a convenient file destination
    c. Attach the completed form to an email
    d. Send to info@westrangedental.com

If the form is received successfully, we will have you sign in the office during your visit.

Note: You may complete the form on your computer, print a completed copy, and bring a copy to your scheduled appointment. You do not have to submit it electronically if you choose not to do so.

WEST RANGE DENTAL CARE

Patient Information and Health History

First Name: _____ **Last Name**: _____ **MI**_____

Sex: ◯Male ◯Female Birth Date(mm/dd/yyyy): _____ Age: _____

Marital Status: ◯Married ◯Single ◯Divorced Other: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Birth Date: _____

Payment Methods: ◯Check/Cash ◯Credit /Debit Card

(Insurance copayments are due on the day of service)

Patient Is: (Check all that apply) ◯ Responsible Party ◯Policy Holder ◯ Dependent/Child

If Minor: Responsible Party _____

Employer _____

Employment Status: ◯Full Time ◯Part Time ◯Retired ◯None

Student Status: ◯Full Time ◯Part Time ◯ Not Applicable

Emergency Contact: _____ Phone# _____

Pharmacy:_____ Previous Dentist:_____

Whom may we thank for referring you? _____

Insurance

Please present your insurance card to reception desk

Payment of deductibles and copays are expected the day of service. Treatment estimates are available upon request.

Insurance Information

Policy Holders Name: _____

Policy Holders Date of Birth (mm/dd/yyyy): _____

Insurance Company Name/Address: _____

_____

Employer: _____ Employer Phone #: _____

Insurance ID#: _____ Group#: _____

Relationship to insured ◯ Self ◯ Spouse ◯ Child ◯ Other

Health Questions

Although dental personnel primary treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician _____ Office Phone_____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No

Have you had a serious head or neck injury? ○ Yes ○ No

Medications List

_____

_____

_____

If answered yes to any of the above please explain:

_____

_____

Women: Are you:

Pregnant/Trying to get pregnant? ○Yes ○No Taking oral contraceptives? ○Yes ○ No Nursing? ○Yes ○ No

Are you allergic to any of the following?

○ **Aspirin** ○ **Penicillin** ○ **Codeine** ○ **Acrylic** ○ **Metal** ○ **Latex** ○ **Local Anesthetics** ○ **Other**

Do you have, or have you had any of the following?

AIDs/HIV ○Yes ○No	**Prednisolone Medicine** ○Yes ○No	**Hemophilia** ○Yes ○No	**Anemia** ○Yes ○No
Immunodeficiency Problem ○Yes ○No	**Diabetes** ○Yes ○No	**Hepatitis A** ○Yes ○No	**Rheumatic Fever** ○Yes ○No
Asthma ○Yes ○No	**Drug Addiction** ○Yes ○No	**Hepatitis B or C** ○Yes ○No	**Rheumatism** ○Yes ○No
Frequent Diarrhea ○Yes ○No	**Easily Winded** ○Yes ○No	**Recent Weight Loss** ○Yes ○No	**Blood Transfusion** ○Yes ○No
Bruise Easily ○Yes ○No	**Emphysema** ○Yes ○No	**Herpes** ○Yes ○No	**Shingles** ○Yes ○No
Artificial Joint Replacement ○Yes ○No	**Epilepsy or Seizures** ○Yes ○No	**Renal Dialysis** ○Yes ○No	**Sickle Cell Disease** ○Yes ○No
Osteoporosis ○Yes ○No	**Fainting Spells/Dizziness** ○Yes ○No	**Sinus Trouble** ○Yes ○No	**Cold Sores/Fever Blisters** ○Yes ○No
Heart Murmur ○Yes ○No	**Heart Attack/Failure** ○Yes ○No	**Kidney Problems** ○Yes ○No	**Use tobacco** ○Yes ○No
Mitral Valve Prolapse ○Yes ○No	**Congenital Heart Disorder** ○Yes ○No	**Leukemia** ○Yes ○No	**Hormone Replacement** ○Yes ○No
Heart Pace Maker ○Yes ○No	**Stroke** ○Yes ○No	**Liver Disease** ○Yes ○No	**Tuberculosis** ○Yes ○No
Blood Pressure Low/High ○Yes ○No	**Frequent Headaches** ○Yes ○No	**Hypoglycemia** ○Yes ○No	**Thyroid Disease** ○Yes ○No
Excessive Bleeding ○Yes ○No	**Irregular Heartbeat** ○Yes ○No	**Lung Disease** ○Yes ○No	**Pain in Jaw Joints/Surgery** ○Yes ○No
Cancer ○Yes ○No	**Angina** ○Yes ○No	**Tumors or Growths** ○Yes ○No	**Bell's Palsy** ○Yes ○No
Chemotherapy or Radiation ○Yes ○No	**Artificial Heart Valve** ○Yes ○No	**Herbal Supplements** ○Yes ○No	○Yes ○No

Explain any other issues:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____

Signature of patient (Or parent/guardian of Minor) Date