Nathalie Tungesvik, DDS
Mollie Lindquist, DDS

Patient Information

Patient Name ____
Last *First* *Middle Initial* *Preferred name*

Birth Date ______/______/_________ **Gender:** Male ___ Female ___ **Social Security**____________________________

IS AN IMMEDIATE FAMILY MEMBER A PATIENT HERE? ____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ______________________________________

Parent/Foster Parent/Legal Guardian Information (Mother/Guardian)

Name ____
Last *First* *Middle Initial* *Preferred name*

Address____
Street *Apt#* *City* *State* *Zip*

Birth Date ______/______/_________ **Gender:** Male ___ Female ___ **Social Security** ____________________________

Home Ph. ____________________________ **Work Ph.**_____________________________ **Cell** ______________________________

E-Mail ____

Employer ______________________________________ **Occupation** ____

Parent/Foster Parent/Legal Guardian Information (Father/Guardian)

Name ____
Last *First* *Middle Initial* *Preferred name*

Address____
Street *Apt#* *City* *State* *Zip*

Birth Date ______/______/_________ **Gender:** Male ___ Female ___ **Social Security** ____________________________

Home Ph. ____________________________ **Work Ph.**_____________________________ **Cell** ______________________________

E-Mail ____

Employer _______________________________________ **Occupation** ____

Dental Insurance Information

Name of Insured________________________ **Relationship to patient**__________ **SS#**__________________Birth Date ____/____/____

Name of employer_______________________________________ Work Phone________________________ Ext.______________

Employer Address____
Street *City* *State* *Zip*

Insurance Company______________________________ Group #________________________ Policy/ID #_________________________

Ins. Co. Address____
Street *City* *State* *Zip*

We will need a copy of your insurance card at your initial appointment. Please bring your insurance card with you for each appointment.

Patient Medical History

Name of Patient's *Primary Care Physician* ____

1. **Is patient under medical treatment now**? Yes____ No____ Please explain ____________________________
2. **Does patient take any medications**? LIST: ____

____

3. **Does patient have any medical allergies**? LIST:____
4. **Does patient take any herbal medicine or supplement?** LIST: ____________________________________

Do you have or have you ever had any of the following? Please Circle

Angina	Diabetes	Infective Endocarditis	Stroke
Arthritis	Emphysema	Kidney Disease	Stomach troubles/Ulcer
Artificial Heart Valve	Excessive Bleeding	Latex Allergy	Thyroid Problem
Artificial Joint	Fainting/Seizures	Liver Disease	Venereal Disease/HIV
Blood Disease	Glaucoma	Lupus	Ventriculoatrial Shunt
Cancer	High Blood Pressure	Mental Disease	**Other** ____________________
Chest Pains	Heart Disease	Radiation Therapy	____________________________
Cardiac Pacemaker	Hepatitis A/B/C	Respiratory Problems	____________________________

Patient Dental History

Name of Previous Dentist ______________________________________ **Date of last exam** ____________________

WHAT IS YOUR IMMEDIATE CONCERN? ____

Check any of the following you have at present or are concerned about:

___Tooth sensitivity ___Teeth clenching or grinding ___Sore or bleeding gums

___Loosening teeth ___Clicking or popping jaws ___Food impaction between teeth

___ Fever blisters on your lips? ___Unpleasant experience from dental treatment

___ Do you have any dental implants, denture, or partials? ___Dissatisfaction with size, shape, color or appearance of teeth

___Other concerns____

* Have you ever had any Orthodontic treatment? Yes___ No___ * Are you interested in Invisalign? Yes___ No___

*****Authorization and Release*****

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 be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the 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 understand that my dental insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents. Finance charge or interest of 1.5% a month will be applied to all balances over 90 days past due.

As a service to our clients, we provide a courtesy appointment reminder email and possibly other important emails that may be sent. By providing your email address, you consent to receiving such notifications.

X____

Signature of patient (or parent/guardian if minor) Date