CHANHASSEN DENTAL

Bradley Lembke, DDS
Todd Weber, DDS

Welcome!

The following confidental information is important for the dentist to know in planning your dental care.
Please answer each question as completely as possible.
Thank You!

Patient Information :

Name:______________________________ Birth Date:____________ SS#______________________

Marital Status: Single ___ Married___Separated___Divorced___Widowed___Minor___

Address:_________________________________ City:______________________St:_____ Zip:________

Home Phone (   )______________ Work Phone (   ) _____________ Cell Phone (   )_________________

E-Mail Address:_____________________________________Occupation:_________________________

Whom may we thank for referring you to our office? ____

Insurance Information:

Primary Coverage

Policyholder:____________________________Birth Date:_______________Go r mq{ gt<______________

Insurance Company: ________________________Group #_________________ID#____________________

Secondary Coverage

Policyholder:____________________________Birth Date:_______________Go r mq{ gt<aaaaaaaaaaaaaaaa

Insurance Company: ________________________Group #_________________ID#____________________

Patient Authorization

Hippa ->>	I hereby authorize Chanhassen Dental to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-determination of treatment plan fees, claims processing, utilization review or financial audit.
Cancelation Policy- >>	I understand a fee may be charged to my account for not providing at least 24 hours notice prior to canceling or rescheduling an appointment.
Disclosure Consent ->>	I give my consent to Chanhassen Dental to discuss with my spouse, family members, or guardian information to facilitate my treatment and/or payment on my account.
Financial Policy ->>	I understand that I am responsible for all charges whether or not they are covered by insurance. A finance charge of 1.5% per month (18% per annum) will be added to accounts not paid when due. An account may be declared in default if not paid in full within 90 days. Upon default I agree to pay 25% collection surcharge calculated on all amounts then due when default is declared, and I also agree to pay court costs and reasonable attorney fees for recovery efforts.

_________I have read the above Authorization, or had it explained to me, and I understand its contents

Patient Signature: ____________________________ Date: _________________

If not financially responsible and/or under the age of 18 yrs of age:

Guardian / Guarantor: Name:________________________________
(Please Print)

Guardian / Guarantor Signature: ______________________ Date: ___________________

Yes No Would you like to know about teeth whitening options or procedures?
Yes No Do you experience migraines?
Yes No Do you snore regularly? Or have you been diagnosed w/ Sleep Apnea?
Yes No Would you like to know more about clear braces for adults and/or children?
Yes No Is your general health good?
Yes No Do you have any allergies to foods, medication (i.e. penicillin, antibiotics, anesthetics, latex, metals, earrings, or other allergies. History of hives / swelling?

If so, which ones?

____

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

Yes No Fainting or Dizzy Spells
Yes No Heart Trouble
Yes No Heart Murmur
Yes No Mitral Valve Prolapse
Yes No Chest Pains
Yes No Artificial (prosthetic) Heart valve(s)
Yes No Stroke
Yes No Asthma
Yes No Bleeding Problems
Yes No Epilepsy (Seizures)
Yes No Hepatitis
Yes No Hemophilia
Yes No Malnourishment
Yes No Systemic Lupus Erythematosus
Yes No Artificial (prosthetic) Joints

Yes No Psychiatric Treatment
Yes No Heart Attack
Yes No High Blood Pressure
Yes No Leaky Heart Valve
Yes No Angina (Chest pains)
Yes No Rheumatic/Scarlet Fever
Yes No Diabetes
Yes No Liver Disease
Yes No Tuberculosis
Yes No Cancer
Yes No Immunsuppresion
Yes No Bruise Easily

(Females Only)
Yes No Are you pregnant?
Yes No Currently taking birth control?

(If yes, when was the artificial joint placed?)_______________
Where? (i.e. hip, knee, etc,)_______________

Yes No Infected Artificial Joint
Yes No Radiation Therapy? What area of the body?_________________________
Yes No Is there any other health information which should be known? (If yes, please note)

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Have you had any unpleasant dental experiences? Yes No (If yes, please explain)

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Are you unhappy with the appearance of your teeth? Yes No (If yes, please explain)

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Yes No Have you been told by your physician to take Pre-Medication prior to dental treatment?

Please list all current medications with dosages (Prescription and over-the-counter)

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Physician name, address, and telphone (if known)

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Patient / Guardian Signature

X______________________________ Date____________________