675 E NICOLLET BLVD, SUITE 120
BURNSVILLE, MN 55337
952-892-7700

PATIENT REGISTRATION FORM

GETTING TO KNOW YOU

NAME: ____
LAST FIRST MIDDLE

Birthdate: ____/____/_____ Age: _____ SSN:______________________

Home Address: ____
Street City State Zip

Home Phone: (____)___________ Business Phone (_____)____________

Cell Phone: (____)__________________ Text ok? _________

Email Address: ____

EMPLOYER: ____

Person Responsible for your account (if other than yourself)

Name: _________________________ Relationship: ___________________

Home Phone: __________________ Work Phone: ____________________

Employer: _______________________ SSN: _________________________

INSURANCE INFORMATION

Primary Dental insurance: ☐ Yes ☐ No

Policyholder's Name: _____________________

Relationship to Policyholder: _______________

Policyholder's Employer:__________________

Insurance Co. Name: ______________________

Group #: __________ Policy #: ______________

Policyholder's Birthdate: ____/____/_____

Policyholder's SSN: ________________________

Secondary Dental insurance: ☐ Yes ☐ No

Please tell us how you heard about our office:

____

Emergency Contact Name: _________________________________ Relationship: ______________ Cell Phone:_________________

DENTAL HISTORY

Reason for Today's Visit:__________________________________ Former Dentist's Name: __________________________

Date of last dental visit: ________________________________ Date of last dental X-Ray: ____________________________

Please CIRCLE "Yes" or "No" indicating if you have or have had any of the following:

Bad breath: yes/no Bleeding gums: yes/no Blisters on lips or mouth: yes/no Burning sensation on tongue: yes/no

Chew on one side of the mouth: yes/no Clicking or popping jaw: yes/no Dry mouth: yes/no Grinding teeth: yes/no

Food collection between your teeth: yes/no Gums swollen or tender: yes/no Jaw pain or tiredness: yes/no

Loose teeth or broken fillings: yes/no Mouth breathing: yes/no Mouth pain when brushing: yes/no

Orthodontic treatment (braces): yes/no Periodontal treatment: yes/no Sores or growth in your mouth: yes/no

Sensitivity to: cold, heat, sweets, when chewing: yes/no Do you regularly brush: yes/no Do you regularly use floss? yes/no

ACKNOWLEDGMENTS

I confirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in strictest confidence and it is my responsibility to inform the office of any changes. I hereby authorize the Doctor to take x-rays, study models, photographs or any other diagnostics aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform the necessary dental treatment, medication, and therapy that may be indicated. I also understand that all dental procedures and the use of anesthetic agents carry a certain risk.

Patient or Guardian Signature____ **Date**_______________________

I certify that I (or my dependent) have insurance coverage with the above named insurance company (companies) and assign directly to Northstar Dental all insurance benefits. I understand that I am financially responsible for all charges: any deductible amount, Co-insurance, or any balance not paid for my insurance company (if I may have one). I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient or Guardian Signature ____ **Date**_______________________