Nathalie Tungesvik, DDS
Mollie Lindquist, DDS
Elana York, DMD

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