



Jeffrey R. Hall, D.D.S.
Bradley D. Lembke, D.D.S.

Welcome!

The following confidential 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# _____

(How would you like to be addressed?) _____

Address: _____ City: _____ St _____ Zip _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Email Address: _____ Appointment Confirmations: ☐ Email ☐ Text ☐ Call

Employer: _____ Occupation: _____

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

Insurance Information:

Primary Coverage

Policyholder: _____ Birth Date: _____ SS# _____

Insurance Company: _____ Group # _____ ID# _____

Secondary Coverage

Policyholder: _____ Birth Date: _____ SS# _____

Insurance Company: _____ Group # _____ ID# _____

PATIENT AUTHORIZATION

Hippa » I hereby authorize Chanhasen 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.

Cancellation 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 Chanhasen 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: _____

Confidential Health Information

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 Do you get canker or cold sores?
Yes No Is your general health good?
Yes No Do you have any allergies to foods, medication
metals, errings or latex, other allergies, history of hives / swelling?

If so, which ones?

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

Yes	No		Yes	N	
Yes	No	Heart trouble	Yes	No	Heart Attack
Yes	No	Heart Murmur	Yes	No	High Blood Pressure
Yes	No	Mitral Valve Prolapse	Yes	No	Leaky Heart Valve
Yes	No	Chest Pains	Yes	No	Angina (Chest pains)
Yes	No	Artificial (prosthetic) Heart valve(s)	Yes	No	Rheumatic/Scarlet fever
Yes	No	Stroke	Yes	No	Diabetes
Yes	No	Asthma	Yes	No	Liver Disease
Yes	No	Bleeding Problems	Yes	No	Kidney Disease
Yes	No	Epilepsy (Seizures)	Yes	No	Tuberculosis
Yes	No	Hepatitis	Yes	No	Cancer
Yes	No	Hemophilia	Yes	No	Immunsuppresion
Yes	No	Malnourishment	Females Only: Are you pregnant ? ____		
Yes	No	Systemic Lupus Erythematosus	Birth Control ?		
Yes	No	Artificial (prosthetic) Joints			

(If yes, when was the artificial joint placed?) _____

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)

Have you had any unpleasant dental experiences? Yes N (If yes, please explain)

Are you unhappy with the appearance of your teeth? Yes N (If yes, please explain)

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)

Physician name, address, and telephone (if known)

Patient/Guardian Signature

X _____ Date _____