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 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: _____

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

Yes ☐ N ☐
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 ☐ Kidney Disease
Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Cancer
Yes ☐ No ☐ Immunsuppresion
Females Only: Are you pregnant ?___
Birth Control ?_____

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**_____