SOUTHERN MINNESOTA PERIODONTICS, & DENTAL IMPLANTS, P.A.

Periodontics and Implants Dentistry
99 Navaho Avenue, Suite 102
Mankato, Minnesota 56001
(507)345-7537

PATIENT INFORMATION:	**INSURANCE INFORMATION:**
Full Name:____________________	**New/Updated** **None** **No Change**
If Child, Name of Guardian:____________________	Dental Insurance Company:____________________
Address:____________________ ____________________	Group #:____________________
Date of Birth:__________ Age:______ **M or F**	Subscriber ID #:____________________
Social Security #:____________________	Please fill out below if the subscriber is someone other than yourself
Cell Phone:____________________	Subscriber's Name:____________________
Home Phone:____________________	Subscriber's Phone #:____________________
Email:____________________	Subscriber's DOB: __________ Relationship:________
Circle which applies: Single Married Child	Subscriber's Employer:____________________
Emergency Contact:____________________	Social Security #:____________________
Relationship:____________________	Please let us know if you have a secondary insurance.
Phone Number:____________________	

I understand I am responsible for any balance not covered by Insurance.

Initials/Date

REFERRAL INFORMATION:

Referral here by:____________________ Current Dentist:____________________

How long you have been seen by present dentist: ____________ Do you see your dentist regularly? Circle **Yes** **No**

Have we treated any family or friends? Circle **Yes** **No**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT – HIPPA

By signing this form, you will consent to our use and disclosure of your protected health of your protected health information (PSI) for the following purposes:

- To conduct and plan treatment, including multiple healthcare providers who may be involved in treatment directly or indirectly.
- To obtain payment for services provided to you through third-party payers (Insurance Companies)
- To conduct normal healthcare operations such as quality assessments, etc.

I have read/been offered a copy of Southern Minnesota Periodontics & Dental Implants, PA's Notice of Privacy Practices (NOPP) containing a detailed description of the uses and disclosures of PSI that we maintain. I understand that I have the right to revoke this consent at any time by giving written notice of my revocation submitted to your office. Please be aware that we may decline to treat you or to continue treating you if you revoke this consent.

Patient:____ Date:______________

Guardian if applicable:________________________________ Date:______________

Please sign this form after we present you with our HIPPA

Medical History

Please list Names of Prescribed Medications:	None	

Please list all Medical Allergies:	None	

GENERAL

Do you require a Pre-Med before dental appointments? **Yes** **No**

TOBACCO USAGE

Do you smoke? **Yes** **No**

If yes, amount per day __________

Do you chew tobacco? **Yes** **No**

FEMALES

Could you be pregnant? **Yes** **No**

HAVE YOU EVER HAD: **None**

- Abnormal bleeding
- Alcohol/Chemical Dependency
- Alzheimer's
- Artificial Joints
- Asthma
- Autoimmune Disorder
- Blood Disorder/Anemia
- COPD
- Dementia
- *Diabetes* **I** or **II** A1C:__________
- Difficulty Breathing
- Fainting Spells
- HIV+/Hepatitis A/B/C, Venereal Disease
- *Artificial Heart Valve*
- Congenital Heart Defect
- High Blood Pressure
- Heart Murmur
- Heart Attack
- Pacemaker
- Heart Condition of:_________________
- Heart Surgery For:________________
- Stroke: Date:______________
- Rheumatic Fever
- Kidney Problems
- Liver Disease
- Nervous Disorders
- Seizures/Epilepsy
- Thyroid Problems
- Cancer-Chemotherapy Year:_______________
- *Radiation Therapy to Head or Neck*

Please list any other conditions or disabilities you would like our office to know about:

DENTAL HISTORY

- Bleeding
- Boils or Abscesses
- Clench/Grind Teeth
- Discomfort
- Extractions Due to Periodontal Disease
- Gum Treatment
- Loose Teeth
- Orthodontic Treatment
- Sensitive Teeth
- Shifting Teeth

Last time your teeth were professionally cleaned: ___________ **Last Cleaning Was Here**

Have you ever had a scaling and root planning (Deep Cleaning) done? **Yes, When:**___________ or **No**

Type of toothbrush you use: **Electric** **Manual** Are the bristles: **SOFT** **MEDIUM** **HARD**

Patient:____ Date:_______________

Guardian if applicable:____ Date:_______________