



1101 S. Columbia Rd., Unit B
Grand Forks, ND 58201
call: (701) 795-1101
fax: (701) 795-1102
www.1101dental.com

Welcome!

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. **Please fill out this form as completely as possible.** We want to make sure that we are well informed about your medical history, current medications, and any other factor that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

ABOUT YOU

Today's Date: _____ How did you hear about us? _____

Patient Name: _____

Patient Prefers to be addressed as: _____ Circle One: **Male** **Female**

Birthdate: _____ Age: _____ SS#: _____

Mailing Address/PO Box: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Employer: _____ Occupation: _____

Circle One: **Single** **Married**

Other Family Members Seen by Us: _____

DENTAL INSURANCE

Please present your dental insurance card upon checking in at the front desk
Do you have dental insurance coverage? **Yes** **No**

If Yes, Please complete the following section:

Dental Insurance Group #: _____

Dental Insurance ID#: _____

If Policy Holder is other than yourself, please fill out the following:

Policy Holder's Name: _____

Policy Holder's Address _____

Relationship: _____

Policyholders Birthdate: _____ SS#: _____

Policy Holders Cell Phone: _____

Alt. Phone: _____

Policyholders Employer: _____

EMERGENCY CONTACT

(Please specify someone who does not live in your household)

Name: _____ Relationship: _____ Phone Number: _____

DENTAL HISTORY

Why have you come to our office today? _____ Are you in pain? **Yes** **No** If yes, for how long? _____

Have you ever been told that you require antibiotics before dental treatment? **Yes** **No**

Would you like whiter teeth? **Yes** **No**

Is there anything about your smile that you would like to change? _____

Do you feel anxiety about dental treatment? **Yes** **No**

Are you happy with your smile? **Yes** **No**

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Do you have a physician? **Yes** **No** Physician's Name: _____ Phone: _____

Date of Last Physical: _____ Current Physical Health: **Excellent** **Good** **Fair** **Poor** **Very Poor**

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? ☐ Yes ☐ No If yes, please explain: _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Amoxicillin
☐ Other _____ If yes please explain: _____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING? IF NOT, PLEASE MARK NO.

AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If Yes, please explain (or other comments): _____

To the best of my knowledge, the questions on this form have been accurately answered and will be held in the strictest confidence. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform this office of any changes in my insurance or medical status.

I also understand that I will be required to pay my estimated portion of Dr. Heather Johnson's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

AUTHORIZATION AND RELEASE

Thank you for choosing 1101 Dental, PLLC for your dental care. We hope to work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions. Benefits of dental treatment include: relief of pain, the ability to chew properly and enjoy eating, and the confidence and social interaction that a pleasing smile can bring. Common risks associated with virtually any dental procedure include:

- **Allergic reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
- **Long-term numbness (parasthesia).** Local anesthesia, or its administration, while almost always adequate to permit comfortable care, can result in temporary, or in rare instances, permanent numbness.
- **Muscle or joint tenderness:** Holding one's mouth open for prolonged periods of time, such as during dental treatment, can result in muscle or jaw joint tenderness. In a predisposed patient, it can precipitate a TMJ disorder.
- **Sensitivity in teeth or gums, infection, or bleeding.**
- **Swallowing or inhaling small objects.**

We follow procedural guidelines that most often lead to clinical success, but as in any other pursuit in health care, not everything always turns out the way it is planned. We will do our best to ensure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you for yourself and for your dependent(s).

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and physicians certification.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

AT YOUR FIRST APPOINTMENT YOU WILL BE ASKED TO ELECTRONICALLY SIGN THAT YOU ACKNOWLEDGE ALL THE ABOVE.