



Section 1 – About You

Patient Name: _____ Today's Date: ____/____/____

What Do You Prefer To Be Called? _____ Male Female

Birth-date: ____/____/____ Age: ____ SS#: _____

Mailing Address: _____ unit/apt.# _____

CITY STATE ZIP
Home Phone #: (____) _____ Work Phone #: (____) _____ ext.# _____

Cell Phone #: (____) _____ E-mail address: _____

How did you hear about us? _____

Section 2 – Dental Info

Reason for today's visit: ____ Exam ____ Emergency ____ Consultation

Are you in pain? No Yes If yes, how long? _____

Please indicate any of the following problems:

| | | | | | | | | | | | |
|---------------------------------------|---|---|-------------------------|---|---|----------------|---|---|-----------------|---|---|
| Discomfort, locking, or noise in jaw | Y | N | Lost/broken filling(s) | Y | N | Stained teeth | Y | N | Ringing in ears | Y | N |
| Red, swollen or bleeding gums | Y | N | Sensitive teeth or gums | Y | N | Bad breath | Y | N | Loose teeth | Y | N |
| Blisters/sores in or around the mouth | Y | N | Broken/chipped tooth | Y | N | Teeth grinding | Y | N | Missing teeth | Y | N |

Others: _____

Do you require pre-medication? Yes No Don't know

Previous Dentist: _____ (____) _____ Last dental exam: ____/____/____ Last dental X-rays: ____/____/____

What type of tooth-brush do you use? Soft Medium Hard Times a day you brush? _____ Times a week you floss? _____

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

What would you like to change about your smile? _____

Section 3 – Medical History

Are you taking any of the following medications?

- Anti-anxiety Pain Killers (including aspirin) Muscle Relaxers Stimulants Blood Thinners
- Tranquilizers Insulin Drugs for Osteoporosis Chemotherapy Recreational Drugs Anti-depressants
- Other(s), please list: _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

| | | | | | | | | | | | |
|---------------|---|---|----------------------------|---|---|-------------------|---|---|-----------------------|---|---|
| Chest Pains | Y | N | High/Low Blood Pressure | Y | N | Tuberculosis (TB) | Y | N | Thyroid Problems | Y | N |
| Scarlet Fever | Y | N | X-ray or Cobalt Treatment | Y | N | Venereal Disease | Y | N | Heart Attack/Stroke | Y | N |
| Nervousness | Y | N | Diabetes/Hypoglycemia | Y | N | Sinus Problems | Y | N | Mitral Valve Prolapse | Y | N |
| Heart Disease | Y | N | Fainting/Seizures/Epilepsy | Y | N | Back Problems | Y | N | Psychiatric Problems | Y | N |
| Shingles | Y | N | Severe/Frequent Headaches | Y | N | Kidney Problems | Y | N | Alcohol/Drug Abuse | Y | N |
| Hepatitis | Y | N | Stomach Problems/Ulcers | Y | N | Liver Problems | Y | N | HIV+ | Y | N |
| AIDS | Y | N | Jaw Problems TMJ/TMD | Y | N | Heart Murmur | Y | N | Arthritis/Rheumatism | Y | N |
| Leukemia | Y | N | Congenital Heart Defect | Y | N | Cancer/Tumors | Y | N | Frequent Neck Pain | Y | N |
| Anemia | Y | N | Heart Surgery/Pacemaker | Y | N | Chemotherapy | Y | N | Bleeding Problems | Y | N |
| Glaucoma | Y | N | Respiratory Problems | Y | N | Rheumatic Fever | Y | N | Difficulty Breathing | Y | N |
| Asthma | Y | N | Artificial Bones/Joints | Y | N | Artificial Valves | Y | N | Emphysema | Y | N |

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? Latex Penicillin/Amoxicillin Tetracycline Aspirin

Dental Anesthetics Others: _____

Do you use tobacco? No Yes If yes; how used? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? Yes No

For women: Are you taking Birth Control pills: Yes No How many children have you had? _____

Are you pregnant? No Yes If yes, how many weeks? _____ Are you nursing? Yes No

Section 4 – Employment/Insurance Info

Employer: _____ Occupation: _____

Employer's Address: _____

CITY _____ STATE _____ ZIP _____

Marital Status: Single Married Divorced Separated Widowed

Spouse's Name: _____ Do you have any children? Yes No

Primary Dental Insurance

Company Name: _____

Address: _____

CITY _____ STATE _____ ZIP _____
Phone #: (____) _____

Insured's SS# or ID#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relation _____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance (if applicable)

Company Name: _____

Address: _____

CITY _____ STATE _____ ZIP _____
Phone #: (____) _____

Insured's SS#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relation _____ Date of Birth: ____/____/____

Insured's Employer: _____

Section 5 – Account Info

Person ultimately responsible for account

Name: _____ Relation: _____

Billing Address: _____ Work Phone #: (____) _____

CITY _____ STATE _____ ZIP _____

SS #: _____ Driver's License #: _____

Payment method: Cash Check Credit Card

[Redacted] I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.
Initials _____

Section 6 – In Event of Emergency

Whom should we contact? _____ Relation: _____

Home Phone #: (____) _____ Work Phone #: (____) _____

Cell Phone #: (____) _____

Who is your Medical Doctor? _____ Medical Doctor's Phone #: (____) _____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. Accounts over 90 days old, without an existing payment arrangement, will be turned over to an attorney, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I give consent to have my blood tested if there is ever an incident exposing another person to my blood.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature **[Redacted]** Date **[Redacted]**

Welcome to Mondale Dental!
10600 Old County Rd. 15, Suite 120
Plymouth, MN 55441 • Phone 763-512-8500 • Fax 763-512-8592
Roger Mondale DDS - Brian Mondale DDS

FOR OFFICE USE ONLY

Chart #: _____
UPDATES
Initials _____ Date ____/____/____
Comments: _____
Initials _____ Date ____/____/____
Comments: _____