Patient Registration

PATIENT NAME: ____**BIRTHDATE:** ____________________

Home Address: ____

Best Phone Number to Reach You During Daytime / Business Hours: _____________________________________

Number Is: Home / Work / Cell / Other

Alternate Phone Number: ______________________________ Number Is: H / W / C / O

E-Mail Address: ____

Referred By: ____

Emergency Contact Name: ____ Phone: _______________________

Minors ONLY:

Person Financially Responsible: _________________________ Relationship: _____________________

Phone Number: ________________________________

Do You Have Dental Insurance? Y / N

If Yes, Please Provide Your Insurance Card for Copy.

Dental Insurance Company: ________________________ Phone Number: _________________________

Claims Mailing Address: ____

Subscriber Name: __________________________________ Subscriber DOB: ________________________

Patient Relationship to Subscriber: _________________ Subscriber ID or SSN: __________________

Group #: _________________________ Subscriber Employer: ____________________________________

What are Your Primary Concerns for Today's Visit? (Please Check all Circles that Apply)

- O Routine Cleaning and Exam
- O Gum / Periodontal Disease
- O Oral Cancer
- O Cavities
- O Losing / Keeping Teeth
- O Appearance
- O General Health
- O Dental Insurance Benefits to Use or Dental Insurance Benefits Ending Soon
- O Other: ____

SIGNATURE: ____ **TODAY'S DATE:** ____________________

Medical History

NAME: ____ **BIRTHDATE:** ________________

- Are you currently under the care of a physician for reasons other than routine medical? Y / N

  If Yes, Physician's name and phone number: __________________________________

- Are you allergic to any of the following: (Please circle)

  Penicillin Latex Sulfa Codeine Metals Novocain Other: ______________

- Do you use tobacco? Y / N If Yes, (Please circle) Smoke / Smokeless

- Are you currently taking any medications? Y / N If Yes, please note on line below, or provide a list for copy.

  ____

- Are you currently taking, or have you taken, Fosamax, Actonel, or Intravenous Bisphonates? Y / N

- Have you had an orthopedic joint replacement? Y / N

  If Yes, What type? __________________ Date of replacement: __________________

- Have you had a heart valve replacement, or do you have a damaged heart valve, requiring pre-med? Y / N

  Date of replacement: ________________

- Do you have: (Please circle)

  Active Tuberculosis (TB)? Cough that produces blood?

  Persistent cough greater than 3 weeks? Have you been exposed to anyone with active TB?

- WOMEN ONLY are you: (Please Circle)

  Pregnant? If pregnant, how many weeks?______________

  Nursing? Taking birth control? Taking hormone replacements?

- Do you have, or have you had, any of the following: (Please check all applicable circles)

- O AIDS / HIV
- O Anemia
- O Angina
- O Arthritis / Rheumatism
- O Asthma
- O Autoimmune disease
- O Blood Transfusion
- O Cancer
- O Cardiovascular Disease
- O Chemotherapy
- O Chronic Pain
- O Congestive Heart Failure
- O COPD
- O Damaged Heart Valves
- O Diabetes I / II
- O Dizziness
- O Eating Disorder
- O Emphysema
- O Epilepsy
- O Fainting
- O GERD / Reflux
- O Glaucoma
- O Heart Attack
- O Heart Disease
- O Heart Murmur
- O Hemophilia
- O Hepatitis
- O High Blood Pressure
- O Kidney Disease
- O Leukemia
- O Liver Disease
- O Low Blood Pressure
- O Low Platelets
- O Mental Health Disorder
- O Mitral Valve Prolapse
- O Neurological Disorder
- O Osteoporosis
- O Pacemaker
- O Persistent Heartburn
- O Prostate Trouble
- O Radiation Treatment
- O Recent Weight Loss
- O Respiratory Disease
- O Rheumatic Fever resulting in heart disease
- O Severe Headaches / Migraines
- O Sexually Transmitted Disease
- O Sinus Trouble
- O Sleep Disorder
- O Stomach / Intestinal Disease
- O Stroke
- O System Lupus Erythematosus
- O Thyroid Problems
- O Tumors or Growth
- O Ulcers
- O Other Not Listed:

  ____

  ____

SIGNATURE: ____ **TODAY'S DATE:** ________________

Dental History

NAME: ____ **BIRTHDATE:** ________________

- Do your gums bleed when you brush or floss? Y / N
- Are your teeth sensitive to: (Please circle)

  Cold Hot Sweets Pressure
- Does food or floss get caught between your teeth? Y / N
- Do you experience dry mouth? Y / N
- Have you ever had periodontal (gum) treatment? Y / N If Yes, Year? ____________________
- Have you ever had orthodontic (braces) treatment? Y / N If Yes, Year? ____________________
- Have you ever had any problems with dental treatment? Y / N

  Please explain: ____
- Are you currently experiencing dental pain or discomfort? Y / N

  Please explain: ____
- Do you have clicking / popping / discomfort in your jaw? Y / N
- Do you, or has anyone ever told you that you, clench or grind your teeth? Y / N
- Do you have sores or ulcers in your mouth? Y / N
- Do you wear partials or dentures? Y / N If Yes, Do you like the way they fit? Y / N
- Date of your last dental exam? _______________________________
- Date of your last dental X-rays? _______________________________
- Reason for your visit today? ____
- How do you feel about your smile? ____
- Is there anything else we should know about you, or your teeth, that will help us to provide the best and most comfortable dental care for you? ____

  ____

SIGNATURE: ____ **TODAY'S DATE:** _____________________

OFFICE/CLINICAL NOTES:

Financial Policy

Payment for all dental treatment is due at the time of service,
unless alternate payment arrangements have been made with our office in advance.

If you are fortunate to have dental insurance:

Ostrem Dental will diagnose the best course of treatment for you based on your dental health,
not your insurance coverage.

It is your responsibility to know and understand the contract between you and your insurance provider.
Ostrem Dental cannot guarantee that any payments will be made by your insurance at any time.

Our office will do it's best to help you utilize your insurance benefits, estimate your patient portions,
and file your insurance claims for you.

Ultimately, you will be responsible for payment for all treatment received,
regardless of any insurance status or determinations.

Signature: ______________________________________ **Date:** _______________

Relationship (If minor or unable to sign for oneself): _____________________________________

Notice of Privacy Practices

This notice describes how dental and medical information about you may be used and disclosed,
and how you can get access to this information.
A notice is posted through binder format in the reception area.

☐ **I acknowledge that I have been provided with a copy of the offices
"Notice of Privacy Practices".**

Ostrem Dental is required by law to maintain the privacy of protected health information
and fulfills its legal duties under the law.

If you are over 18 years of age, and would like information regarding your care disclosed to parties other than those stated by law, please list the full name and relationship below.

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

Your Signature: ____ Today's Date: _______________________

Revised 5/25/2016

RELEASE OF RECORDS TO OSTREM DENTAL

PATIENT NAME: ____

DOB: ____

I, _________________________________, request _______________________ to release the following records to Ostrem Dental:

________ Bitewing X-rays from last 12 months

________ Full Mouth X-rays from last 5 years

________ Panorex X-rays from last 5 years

Please email above records to: contactus@drodental.com
If you cannot email the x-rays, please mail them to:

Ostrem Dental
4600 Lake Road Ave, Ste 101
Robbinsdale, MN 55422

If you have questions, please call our office at 763-536-1272.

PRINT NAME: ____

SIGNATURE: ____

DATE: ____