DAKOTA DENTAL
AND WELLNESS CENTER
A Different Kind of Dentistry

New Patient & Health History Information

Although we primarily treat diseases of the mouth, we recognize the important interrelationship between the health of the mouth and the rest of the body. To assist us in better caring for you, please complete the following form to the best of your knowledge. The information provided is important for us to deliver ideal and safe dental care to you.

Patient's Name:_____ Preferred name:_____ Birth Date:___/____/____

Home Address:_____City:_____State:_____ Zip: _____

Phone: (_____) _____ Email:_____

Social Security Number:_____ Height:_____ ft _____ inches Weight:_____ lbs

Who may we thank for referring you to our office? _____

Are you under the care of a physician presently? ❑ Yes ❑ No

If yes, please explain for what?_____

Have you had an operation or been hospitalized in the past 5 years? ❑ Yes ❑ No

If yes, please explain for what?_____

Have you or a family member, had any unusual or serious reaction to anesthetics? ❑ Yes ❑ No

Has a physician recommended that you take antibiotics prior to dental treatment? ❑ Yes ❑ No

I decline to receive fluoride as part of my oral treatment. ❑ Yes ❑ No

Do you have, or have you had, any of the following:

	Yes	No		Yes	No		Yes	No
Anemia	❑	❑	Gallbladder Trouble	❑	❑	Night Sweats	❑	❑
Anxiety	❑	❑	Gastric Reflux	❑	❑	Nursing an Infant	❑	❑
Angina / Chest Pain	❑	❑	Hay Fever	❑	❑	Osteoporosis/osteopenia	❑	❑
Artificial Heart Valve	❑	❑	Heart Attack/Failure	❑	❑	Osteonecrosis	❑	❑
Asthma	❑	❑	Hepatitis	❑	❑	Pregnancy, ANY Chance	❑	❑
Birth Control	❑	❑	Heart murmur	❑	❑	Pacemaker	❑	❑
Blood Transfusions	❑	❑	Heart malformation	❑	❑	Prosthetic Joint or Implant	❑	❑
Cancer	❑	❑	High Blood Pressure	❑	❑	Retinopathy	❑	❑
Contact Lens	❑	❑	High Cholesterol	❑	❑	STDs	❑	❑
Contagious Diseases	❑	❑	Irregular Heartbeat	❑	❑	Sleep Apnea / Snoring	❑	❑
Convulsions / Epilepsy	❑	❑	Immunocompromised	❑	❑	Smoking or Tobacco Use	❑	❑
Chronic Fatigue	❑	❑	Jaundice / Yellowing	❑	❑	Stroke	❑	❑
Diabetes	❑	❑	Jaw Joint Pain / Clicking	❑	❑	Substance Abuse	❑	❑
Dialysis	❑	❑	Kidney problems	❑	❑	Swollen ankles / arthritis	❑	❑
Emphysema / COPD	❑	❑	Liver Disease	❑	❑	Transplants	❑	❑
Eye Disease	❑	❑	Low Blood Pressure	❑	❑	Tuberculosis	❑	❑
Excessive Bleeding	❑	❑	Lung Disease	❑	❑	Tumors or Growths	❑	❑
Fainting Spells	❑	❑	Mental Health Concerns	❑	❑	Ulcers	❑	❑

Do you wish to speak to the Doctor privately about anything? ❑ Yes ❑ No

Family History of Cancer, Diabetes, or Anesthesia Problems? ❑ Yes ❑ No

Have you ever had any serious illness or condition not listed above? ❑ Yes ❑ No

Are you allergic to, or had a reaction with:

❑ Aspirin ❑ Anesthetics ❑ Acrylic ❑ Antibiotics ❑ Codeine or Narcotics ❑ Sulfites ❑ Other Medications

Do you have any serious allergies that are not listed? _____

Please List any medications you are currently taking:(Medication, Dosage, Frequency)

_____

_____

What is the pharmacy you would like relevant prescription medications sent?

Store Name:_____ City:_____ Address:_____

Primary Dental Insurance

Subscriber Name: _____ Relationship to Patient: _____

SSN: _____ DOB: _____ Employer: _____

Subscriber ID: _____ Group: _____

Secondary Dental Insurance

Subscriber Name: _____ Relationship to Patient: _____

SSN: _____ DOB: _____ Employer: _____

Subscriber ID: _____ Group: _____

Medical Insurance

Subscriber Name: _____ Relationship to Patient: _____

SSN: _____ DOB: _____ Employer: _____

Subscriber ID: _____ Group: _____

Responsible Party Name: _____ Relationship to Patient: _____

Address: _____ Phone: _____

I certify that I have read and I understand the questions above. I knowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in completion of this form. I authorize my surgeon and his/her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

X_____ X_____ Date:___/_____/_____

Signature of patient or Responsible Party Reviewed By MM DD YYYY