North Star Dental Patient Information

Name: _____Preferred Name: _____ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] other Birth Date: ___/___/___ Patient S.S. #: _____

Mailing Address: _____City: _____State: _____Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May we contact you at work? [ ] Yes [ ] No E-Mail Address: _____

Employer: _____ Occupation: _____

Person Responsible for Account

[ ] Same as Above Name:_____ Birth Date: ___/___/___ Relation: _____

Billing Address: _____City: _____State:_____Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____ S.S. #: _____

Spouse Name: _____ Spouse Employer: _____ Birth Date: ___/___/___

Emergency Contact

Name: _____ Relation:_____ Phone:_____

Dental Insurance Information

Primary Insurance: _____Subscriber Name: _____Employer:_____

Subscriber Birth Date: ___/___/___ Subscriber S.S. # or Identification #:_____

Secondary Insurance: _____Subscriber Name: _____Employer: _____

Subscriber Birth Date: ___/___/___ Subscriber S.S. # or Identification #: _____

Authorization and Consent

I give consent to Dr. David Paape and staff to perform any services necessary in the course of my treatment. I understand that during treatment unforeseen conditions may arise which may necessitate procedures different from those discussed prior to treatment. I therefore consent to the performance of any additional treatment which the dentist considers necessary.

Signature: _____ Date: _____

Patient Health History

Do you or have you had any of the following? Please circle **Y** for yes and **N** for no.

Y / N Heart Disease
Y / N Heart Murmur**/** Mitral Valve Prolapsed
Y / N Stoke
Y / N Congenital Heart Lesions
Y / N Abnormal Blood Pressure
Y / N Excessive Urinations and/or Thrust
Y / N Diabetes
Y / N Prolonged Bleeding Disorder
Y / N Tuberculosis or Lung Disease
Y / N Asthma
Y / N Hay Fever
Y / N Sinus Trouble
Y / N Epilepsy / Seizure
Y / N Ulcers
Y / N History of Drug Addition
Y / N Liver Disease
Y / N Jaundice
Y / N Kidney Disease
Y / N Hepatitis Type: **A** / **B** / **C**
Y / N HIV **/** AIDS
Y / N Immune Suppression Disorder
Y / N Herpes
Y / N Infectious Mononucleosis (Mono)
Y / N Sexually Transmitted**/** Venereal Disease
Y / N Rheumatic Fever
Y / N Arthritis
Y / N Anemia
Y / N Tumor or Malignancy
Y / N Cancer**/** Chemotherapy
Y / N Radiation Treatment
Y / N Hearing Loss
Y / N Glaucoma
Y / N Fainting spells
Y / N History Of Emotional or Nervous Disorder

Have you been hospitalized during the last 5 years?
If Yes, Explain:_____
_____

Are you Allergic to any of the following:
Y / N Aspirin
Y / N Ibuprofen
Y / N Sulfa Drugs / Sulfides / Sulfites
Y / N Penicillin
Y / N Codeine
Y / N Latex / Metals / Plastics
Y / N Local Anesthetics (Novocain)
Y / N Other Medications – Which ones? _____
_____

Do you have any other medical problems or medical history NOT listed on this form? _____
_____

Women

Are you pregnant? If yes, how many weeks? _____
Are nursing? Y/N

Please list all medications you are currently taking:
Medicine _____**Condition**_____
Medicine _____**Condition**_____
Medicine _____**Condition**_____
Medicine _____**Condition**_____
Physician's Name _____
Physician's Phone _____
Address _____**Fax** _____

How did you hear about our office?

[ ] Internet
[ ] Google
[ ] Yellow Pages
[ ] Insurance Co.
[ ] Business Sign
[ ] ValPak
[ ] 1-800-Dentist
[ ] 10anchoragecoupons.com
[ ] Referred by a friend/family member: _____
[ ] Other:_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held confidential, and it is my responsibility to inform this office of any changes in my medical status/history.

Signature: _____Date:___/___/___

For Office Use Only

Doctors Signature: _____

Doctor's Comments: _____