Northpointe Dental Care
Craig L. Rathjen, D.D.S.

Patient information:

Dr. Mr. Mrs. Ms._____ Date of birth_____
Address _____ Marital status S M W D (child)
City _____Zip_____ SS#_____
Home phone # _____ Work #_____ Cell #_____

Employer _____
Full time student? Y N Where? _____
Spouse's name _____ Spouse's work #_____
Whom may we thank for referring you? _____

Responsible party information:

Please note- if information is same as above, you may skip this section.

Dr. Mr. Mrs. Ms. _____ Date of birth_____
Address _____ Marital status S M W D
_____ SS#_____
Home phone # (___)_____Work #_____ Cell #_____
Employer _____
Relationship to the patient _____

Insurance information:

Primary:
Subscriber _____ Date of birth_____
Employer _____ SS#_____
Insurance company _____ Group #_____
Phone # _____

Secondary:
Subscriber _____ Date of birth_____
Employer _____ SS#_____
Insurance company _____ Group #_____
Phone # _____

Emergency information:

In case of emergency- whom may we contact?
Name _____ Relationship to patient_____
Home phone # _____ Work phone # _____

Authorization:

I authorize the dental staff to perform the necessary services to myself or my minor child.

I authorize my insurance company to pay Dr. Rathjen/ Northpointe Dental Care all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Dr. Rathjen to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

_____
signed by person financially responsible *date*

_____
relationship to patient

The following medical questionnaire is for your record only and will be kept confidential.

Health History:

Physician's name _____ Phone # _____ Date last seen _____

Y N Are you under active care by a physician? Please explain. _____

_____

Y N Have you been hospitalized in the last 10 years? Please explain. _____

_____

Y N Have you taken prescribed or non-prescribed narcotics or drugs in the last 30 days? Please explain _____

_____

Y N Are you sensitive or have you ever had a negative reaction to Novocaine____ Latex____Codeine____Aspirin____

Y N Do you have a pacemaker?

Y N Do you have any prosthetic device like an artificial heart valve or joint?

Y N Have you ever had to premedicate prior to any dental procedure?

Y N Do you smoke or use any tobacco product? Please explain. _____

Y N Women- are you pregnant? Y N What trimester?____ Are you attempting pregnancy? Y N

Are you taking birth control pills? Y N Are you nursing? Y N

Indicate which of the following if any you have had or have at present:

Y N Stomach or intestinal problems

Y N Rheumatic fever

Y N Heart murmur

Y N Hepatitis type_____

Y N Tuberculosis

Y N High or low blood pressure

Y N Tumors or growths

Y N Diabetes

Y N Respiratory disease (asthma, emphysema, etc.)

Y N Seizures

Y N Cancer, chemotherapy or radiation therapy

Y N Arthritis

Y N Liver disease/jaundice

Y N Kidney disease

Y N Heart disease or disorder

Y N HIV, ARC or AIDS

Y N herpes I or II, apthous ulcers

Y N Blood disease, bleeder or slow healer

Y N Chemical/drug dependency

Y N Thyroid problem

Any other conditions not listed above_____

If yes to any of the above please explain.

_____

_____

_____

Medications:

List any medications you are currently taking.
(prescription, non-prescription, herbs or vitamins)

_____

_____

_____

Allergies:

List any known allergies.
(environmental and medications)

_____

_____

_____

Dental History:

Reason for today's visit _____

Date of last dental exam _____ x-rays _____ cleaning _____

Please indicate any areas of concern or interest:

Y N bad breath

Y N burning sensation on tongue

Y N dry mouth

Y N jaw pain or tiredness

Y N broken teeth or fillings

Y N ear pain

Y N sensitivity to biting

Y N orthodontics (braces)

Y N bleeding gums

Y N chewing on only one side

Y N food collecting between teeth

Y N swollen or tender gums

Y N mouth breathing

Y N sensitivity to hot or cold

Y N sores or growths in mouth

Y N bleaching

Y N blisters on lips or mouth

Y N clicking or popping jaw

Y N grinding or clenching

Y N loose teeth

Y N mouth pain

Y N sensitivity to sweets

Y N missing teeth

Y N cosmetics

Is there anything about your teeth or smile you'd like to change, if possible?

_____

_____

_____