BISMARCK
ADVANCED DENTAL
AND IMPLANTS

We warmly welcome you to our office. Please take a few moments to complete the following information so that we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Patient Information

Circle One: Mr. Mrs. Dr. Ms. Miss

Name: _____

I prefer to be called: _____

Birthdate: _____/_____/_____ Male Female

Social Security Number: _____

Home Address: _____

_____

Home Phone:_____ Cell Phone:_____

Email: _____

How do you prefer to confirm your appointments?

Call Text Email Postcard

Employer: _____

Occupation: _____

How did you hear about us? _____

Who referred you? _____

Other family members seen by us? _____

Previous/Present Dentist: _____

Date of late visit: _____/_____/_____ Phone: _____

Current x-rays? Yes No

Dental Insurance

Primary Dental Insurance:

Insurance Company Name: _____

Subscriber ID: _____ Group ID: _____

Insured's Name: _____

Relation: _____ Insured's DOB: _____/_____/_____

Insured's SSN: _____

Address: _____

_____

Phone: _____

Secondary Dental Insurance:

Insurance Company Name: _____

Subscriber ID: _____ Group ID: _____

Insured's Name: _____

Relation: _____ Insured's DOB: _____/_____/_____

Insured's SSN: _____

Address: _____

_____

Phone: _____

In the event of an emergency, who should we contact?

Name: _____

Relation: _____

Cell phone: _____ Home phone: _____

A note for patients with dental insurance – We will assist you to maximize your insurances benefits, and we are happy to file claims to your insurance carrier and agree to accept payment from your carrier that offers an assignment of benefits, if you desire. We will do our best to calculate your available benefits amount and potential patient portion, however, regardless of what your insurance plan pays, you are responsible for all fees.

Have you ever had any of the following health conditions?

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Alcohol/Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV/AIDS
Y	N	Angina Pectoris	Y	N	Hospitalizations
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial bones/joints/valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Mitral Valve Prolapse
Y	N	Cancer/Chemotherapy	Y	N	Nervous/Anxious
Y	N	Colitis	Y	N	Osteoporosis
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic/Scarlet fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Sleep Apnea
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tumors
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease
Y	N	Hepatitis	Y	N	Yellow Jaundice

Do you have, or have you had any conditions not listed:

_____

_____

_____

Are you currently taking any medications? Y N

If yes, please list:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following items?

Y	N	Tetracycline	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Aspirin
Y	N	Erythromycin	Y	N	Amoxicillin
Y	N	Seasonal	Y	N	Metals
Y	N	Sulfa	Y	N	Other

If other, please list: _____

_____

_____

_____

Are you currently being treated by a physician? Y N

Do you use or smoke tobacco products? Y N

Are you experiencing pain in your teeth/gums? Y N

Do you grind/clench your teeth? Y N

Experience jaw pain? Y N

Treated for TMJ symptoms? Y N

Are you happy with the look of your teeth? Y N

Are your teeth sensitive to: Heat Cold Pressure Sweets

What's most important to you about your teeth?

_____

_____

What's most important to you about the dental care you receive? _____

_____

For Women:

Birth Control? Y N

Are you nursing? Y N

Are you currently pregnant? Y N

If yes, when are you due? _____

How many weeks along? _____

Medical History Consent

I grant that any information regarding dental and/or medical care provided by Bismarck Advanced Dental and Implants may be received by the following people:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____

Bismarck Advanced Dental and Implants
Dr. Derik Hoerner, DDS
Dr. Christopher Klym, DMD
1004 S 7th St
Bismarck, ND 58504
701.955.5111 www.dentalimplantsnorthdakota.com

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me, and to use the appropriate medication and therapy indicated for such treatment in connection with the patient named on this form. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of services rendered unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 18% finance charge may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be ordered.
5. I understand that is it my responsibility to advise your office of any changes in the information obtained.
6. I authorize the use of my social security number to file my dental claims.