Kenneth B Weddell, PLLC
The Penncrest Building
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Bloomington, MN 55431
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WEDDELL DENTAL
HEALTH AND BEAUTY

Phone: 952-884-7706
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Patient Information

Name_____ Soc. Sec. #_____
Last Name First Name Middle Initial

Address_____

City_____State_____Zip_____Home Phone_____

Cell Phone_____E-mail_____

Sex ☐M ☐F Age_____ Birthdate_____ ☐Single ☐Married ☐Widowed ☐ Separated ☐Divorced

Patient Employed by_____ Occupation_____

Business Address_____City_____State_____Zip_____

Business Phone_____ Business E-mail_____

How did you hear about us? ☐Ad in Mail ☐Our Website☐Insurance Company ☐ Family/Friend Who?_____

How would you like to be notified of appointment reminders: ☐ Text Message ☐ E-mail ☐ Mail ☐ Home Phone

Notify in case of Emergency_____ Relation to Patient_____

Phone #_____ E-mail_____

Previous Dentist Name and Address_____

Phone #_____ Last Dental Visit:_____

Please help us learn more about you by answering the following questions:

Are you having any concerns or dental discomfort? _____

_____

Is there anything you would like to change about your teeth/smile? _____

_____

Is there anything else you feel we should know? _____

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Primary Insurance

Insurance Company _____ Phone:_____

Member ID Number _____ Group Number_____

Employer: (Name of employer through which you are insured)_____
*If plan has been purchased individually, please state "Self"

Name of other dependents under this plan_____

Policy Holder Information: (This is the main person on the plan, ex. Spouse or Parent)

Name_____ Relationship to Patient_____
Last Name First Name Middle Initial

Date of Birth_____ Soc. Sec.#_____

Address_____City_____MN_____ Zip_____

Home Phone_____ Cell Phone _____ E-mail_____

Business Address_____

Business Phone_____ Business E-mail_____

Secondary Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No If yes, please fill out form below:

Insurance Company _____ Phone:_____

Member ID Number _____ Group Number_____

Employer: (Name of employer through which you are insured)_____
*If plan has been purchased individually, please state "Self"

Name of other dependents under this plan_____

Policy Holder Information: (This is the main person on the plan, ex. Spouse or Parent)

Name_____ Relationship to Patient_____
Last Name First Name Middle Initial

Date of Birth_____ Soc. Sec.#_____

Address_____City_____MN_____ Zip_____

Home Phone_____ Cell Phone _____ E-mail_____

Person Responsible Employed by _____ Occupation_____

Business Address_____

Business Phone_____ Business E-mail_____

Authorization

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist 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.

Signature_____Date_____

Payment is due in full at the time of treatment, unless prior arrangements have been approved.

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Medical History

Name_____ Date of Birth_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes

(Includes primary physician)

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No Please list below.

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No
Please list below.

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Women: Are you.... ☐ Does not apply

☐ Pregnant / Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other allergy? If yes

Do you use controlled substances? ☐ Yes ☐ No If yes

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Medical History Continued

Do you have, or have you had, any of the following? Please check if "Yes".

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Yellow Jaundice
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Sleep Apnea
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's health). It is my responsibility to inform the dental office of any changes in medical status.

_____ Signature of Patient, Parent or Guardian

_____ Date