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_____ State_____ 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_____ State_____ 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**

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….

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

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**