Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

MARKO M. KAMEL, DDS, FAGD, MIDIA• 2070 Eagle Creek Lane, Suite 300• Woodbury, MN 55129• (651) 436-7559

PATIENT INFORMATION

Name ______________________________ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: __________
First MI Last

Address ______________________________ Occupation: ____________________ [ ] Male [ ] Female

City ____________________ State ________ Zip __________ Hm# (___)____________________

Employer ______________________________ Wk# (___)________________Ext ________

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell # (____)________________

DOB: ____/_____/_____SSN# ____________________ E-mail ________________@__________

Spouse's Name ______________________________
First MI Last (if different)

Spouse occupation ______________________________ Work phone ____________________Ext ________

Is patient a full time student? [ ] No [ ] Yes: Name of school: ______________________________

RESPONSIBLE PARTY (if different than patient)

Name ______________________________
First MI Last

Address ______________________________

City ____________________ State ______ Zip ________

Hm# (___)____________________

Wk# (___)____________________

DOB: ____/_____/______

SSN# ____________________

Relationship: ______________

EMERGENCY CONTACT:

Name______________________________
First MI Last

Cell# (____)____________________

YOUR PREFERENCES

Do you prefer appointment reminders by: [ ] Email [ ] Phone [ ] Text
Do you prefer to receive calls from our office at: [ ] Home [ ] Work [ ] Cell
Whom may we thank for referring you? How do you wish to be addressed by our staff?

____________________ ____________________

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name ______________________________ Relationship to patient: ____________________

DOB: ______/______/________ Subscriber's SSN# ____________________

Insurance Company ____________________ Policy # ______________ Group #________________

DENTAL INSURANCE:

Insured Name ______________________________ Relationship to patient: ____________________

Address ______________________________ City ______________ State ______ Zip ________

DOB: ____/___/________SSN# ____________________ Employer: ______________________________

Insurance Company ____________________ Subscriber ID # ______________ Group #______________

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Insured Name ______________________________ Relationship to patient: ____________________

Address ______________________________ City ______________ State ______ Zip ________

DOB: ____/___/________SSN# ____________________ Employer: ______________________________

Insurance Company ____________________ Group # ____________________ Eff. Date: ___/___/____

Our practice is one of the most advanced CAD/CAM practices in the US. We use 3-D CEREC technology to produce ceramic restorations in a single visit.

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FOR OFFICE USE ONLY:
D I S C

MEDICAL/DENTAL HISTORY and CONSENT

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

THIS BOX FOR WOMEN ONLY:
Are you taking birth control pills? Y N
Are you pregnant? Y N
If yes, number of weeks? _____
Are you nursing? Y N

Allergies
Acrylics Y N
Anaphalaxis Y N
Latex Y N
Local Anesthetics Y N
Penicillin Y N
Metal Y N
Sulpha Y N
Other Y N
List other known allergies:

____

____

Cardiovascular
Artificial Heart Valve Y N
Coronary Artery Disease Y N
Chest Pain or Angina Y N
Congestive Heart Failure Y N
Heart Attack Y N
Heart Murmur Y N
High Blood Pressure Y N
High Cholesterol Y N
Irregular Heart Beat Y N
Low Blood Pressure Y N
Mitral Valve Prolapse Y N
Pacemaker Y N
Tachycardia Y N

Endocrine
Diabetes Y N
Gout Y N
Hormonal Change Y N
Thyroid problems Y N

Eyes, Ears, Nose and Throat
Change in Hearing Y N
Change in Vision Y N
Dysphagia Y N
Ear Pain Y N
Glaucoma Y N
Hay Fever Y N
Nasal Obstruction Y N
Nose Bleeding Y N
Sinus Problems Y N
Tonsillectomy Y N
Tinnitus Y N

Gastrointestinal
Acid Reflux Y N
GERD Y N
Soft or Special Diet Y N
Ulcers Y N

Genitourinary
Frequent Urination Y N
Kidney disease Y N
Nocturia Y N

General
Current weight: _________lbs
Height: _______ ft ______in
Cancer Y N
Fatigue/Tired Y N
General Weakness Y N
Headaches Y N
HIV/AIDS Y N
Knee/hip replacement Y N
Liver problems Y N
Recent Trauma or Injury Y N
Rheumatic Fever Y N
Radiation Treatment Y N
Weight Change Y N
Arthritis Y N

Hematological
Bleeding problems Y N
Hepatitis Y N

Oral
Bleeding gums Y N
Dry mouth Y N
Jaw problems (TMJ)? Y N
Clicking? Y N
Pain? Y N
Difficulty swallowing? Y N
Difficulty chewing? Y N
Orthodontics/Invisalign Y N
Periodontal Disease Y N
Teeth clenching Y N
Teeth grinding Y N
Tooth pain Y N
Wisdom teeth extraction Y N
Do you wear removable teeth? Y N

Do you take or need antibiotics before dental procedures? Y N
Sensitivity? Y N
Whitening? Y N

Musculoskeletal
Back Pain Y N
Fibromyalgia Y N
Joint Pain Y N

Neurological
Alzheimer's Disease Y N
Dizziness Y N
Fainting Y N
Memory Loss Y N
Multiple Sclerosis (MS) Y N
Muscle Weakness Y N
Seizures Y N
Stroke Y N
Tingling/Numbness Y N
Trigeminal Neuralgia Y N
Tremor Y N

Psychiatric
ADD/ADHD Y N
Anxiety Y N
Chemical Dependency Y N
Depression Y N
Eating disorders Y N
Excessive Stress Y N
Memory problems Y N

Respiratory
Asthma Y N
Bronchitis Y N
Breathing problems Y N
Chest Pressure Y N
Congestion Y N
Dyspnea(shortness of breath) Y N
Emphysema Y N
Orthopnea Y N
Pneumonia Y N
Pulmonary Embolism Y N
Tuberculosis Y N

Sleep
Daytime Sleepiness Y N
Morning headaches Y N
Obstructive Sleep Apnea Y N
Do you use a CPAP? Y N
How often? ________________
Has anyone told you that you snore? Y N

Social History
Do you smoke? N Y ___ packs a day
Do you use smokeless tobacco? Y N
Do you consume alcoholic beverages?
_____Drinks per day/week/month

Do you use recreational drugs? Y N

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List any medications you are taking:

	Medication	Dosage/Freq.	Prescriber	Reason
1.				
2.				
3.				
4.				
5.				
6.				

List any surgeries or hospitalizations you have had:

Date (year)	Surgery	Surgeon	Reason

List and detail any medical condition or history not listed above:

____

____

____

____

Primary Physician's Name: ______________________________ Physician's phone #: ______________

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

______________________ Signature of Patient/Guardian — Date __________ — ______________________ Staff Signature

______________________ Signature of Patient/Guardian — Date __________ — ______________________ Staff Signature

______________________ Signature of Patient/Guardian — Date __________ — ______________________ Staff Signature

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