



Welcome To Our Practice

John J. Keller D.D.S.

552 East Main Street • Anoka, MN 55303

PATIENT INFORMATION

Date _____

Patient's Name _____

Date of Birth _____

If Child: Parent's Name _____

How do you wish to be addressed? _____

Street Address _____

City _____ State _____ Zip _____

Telephone: Home _____

Cell Phone _____ Bus. _____

Employer Name _____

Business Address _____

Patient / Parent Social Security No. _____

Patient / Parent Employed By: _____

Present Position _____

How Long Held _____

Spouse / Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is responsible for this account? _____

Method of co-payment: Check _____ Cash _____
Credit Card _____

Someone to notify in case of emergency:

Other Family Members in this Practice _____

Whom may we thank for this referral: _____

DENTAL Primary Coverage

Employee Name _____

Employee Date of Birth _____

Employer Name _____

Employer Phone No. _____

Insurance Co. Name _____

Insurance Co. Phone No. _____

Insurance Co. Address _____

Group / Policy No. _____

Union / Local _____

Social Security No. _____

DENTAL Secondary Coverage

Employee Name _____

Employee Date of Birth _____

Employer Name _____

Employer Phone No. _____

Insurance Co. Name _____

Insurance Co. Phone No. _____

Insurance Co. Address _____

Group / Policy No. _____

Union / Local _____

Social Security No. _____

PATIENT AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I have been given the "Notice of Privacy Practices" from Dr. John Keller's office and am aware of my privacy rights.

I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I understand that my dental insurance or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements, and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.

Patient or Guardian's Signature _____ Date _____

(over)

HEALTH HISTORY

Physicians' Name _____ Date of Last Visit _____

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

Artificial Joints	Yes <input type="checkbox"/> No <input type="checkbox"/>	Chemical Dependency	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Lung Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Alcoholism	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Smoker _____ pks/day	Yes <input type="checkbox"/> No <input type="checkbox"/>	Venereal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Weight Loss / Unexplained	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Abnormal Bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>
Back Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Artificial Heart Valves	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches AM / PM	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy / Radiation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swollen Feet or Ankles	Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis Type _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Thyroid Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitrovalve Prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>
AIDS / HIV	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric Care	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sinus Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>

Today's Blood Pressure _____ / _____

Women:

Are you pregnant? _____ Due date _____ Are you nursing? _____

MEDICATIONS:

REASON FOR TAKING:

ALLERGIES:

Aspirin
 Barbiturates
 Codeine
 Iodine
 Latex
 Local Anesthetic
 Penicillin
 Sulfa
 Other _____

Premedication Rx _____ Pharmacy Name _____ Phone Number _____

DENTAL HISTORY

Reason for today's visit _____	Burning tongue / lips	Yes <input type="checkbox"/> No <input type="checkbox"/>	Loose teeth	Yes <input type="checkbox"/> No <input type="checkbox"/>
Former Dentist _____	Frequent blisters	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dry mouth	Yes <input type="checkbox"/> No <input type="checkbox"/>
City/State _____	Swelling, lumps in mouth	Yes <input type="checkbox"/> No <input type="checkbox"/>	Clenching / grinding habit	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date of last dental visit _____	Biting cheek / lip	Yes <input type="checkbox"/> No <input type="checkbox"/>	Clicking / popping jaw	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date of last x-rays _____	Sensitivity to hot	Yes <input type="checkbox"/> No <input type="checkbox"/>	Difficulty opening or closing	Yes <input type="checkbox"/> No <input type="checkbox"/>
Home water source: city or private well	Sensitivity to cold	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches AM / PM	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you having any discomfort at this time?	Sensitivity to sweets	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaw pain / ear pain	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	Sensitivity to bitings	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bleeding / sore gums	Yes <input type="checkbox"/> No <input type="checkbox"/>

Thank you for choosing us for your dental care.