

**PATIENT REGISTRATION**

ID: \_\_\_\_\_

Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder  Responsible Party

Preferred Name: \_\_\_\_\_

Responsible Party ( if someone other than the patient )

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Soc Sec: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient

Primary Insurance Policy Holder

Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State / Zip: \_\_\_\_\_

Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

Cellular: \_\_\_\_\_

Sex:  Male  Female

Marital Status:  Married  Single

Divorced

Separated

Widowed

Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_

Soc Sec: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg: \_\_\_\_\_

Referred by? \_\_\_\_\_  
Emergency Contact \_\_\_\_\_  
Emergency Contact # \_\_\_\_\_  
Do you have medical insurance? If so, please provide card. \_\_\_\_\_

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

# Dresen Restorative Dentistry Dental History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Dentist: \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_  
\_\_\_\_\_

Are you presently in any pain?  Yes  No For how long? \_\_\_\_\_  
Hot/Cold  Yes  No Biting/Pressure  Yes  No Swelling  Yes  No

Are you wearing anything removable to replace missing teeth?  Yes  No  
How old are they? \_\_\_\_\_ Are They Comfortable?  Yes  No

Are you satisfied with:  
The appearance of your teeth?  Yes  No  
Your ability to chew & eat?  Yes  No

What would you like to change about your mouth, teeth or smile? \_\_\_\_\_  
\_\_\_\_\_

When was your last dental appointment? \_\_\_\_\_  
What was done? \_\_\_\_\_

Have you or are you having any head or neck pain?  Yes  No

Do you have frequent headaches?  Yes  No

Have you ever noticed any popping or clicking of your jaw joint?  Yes  No

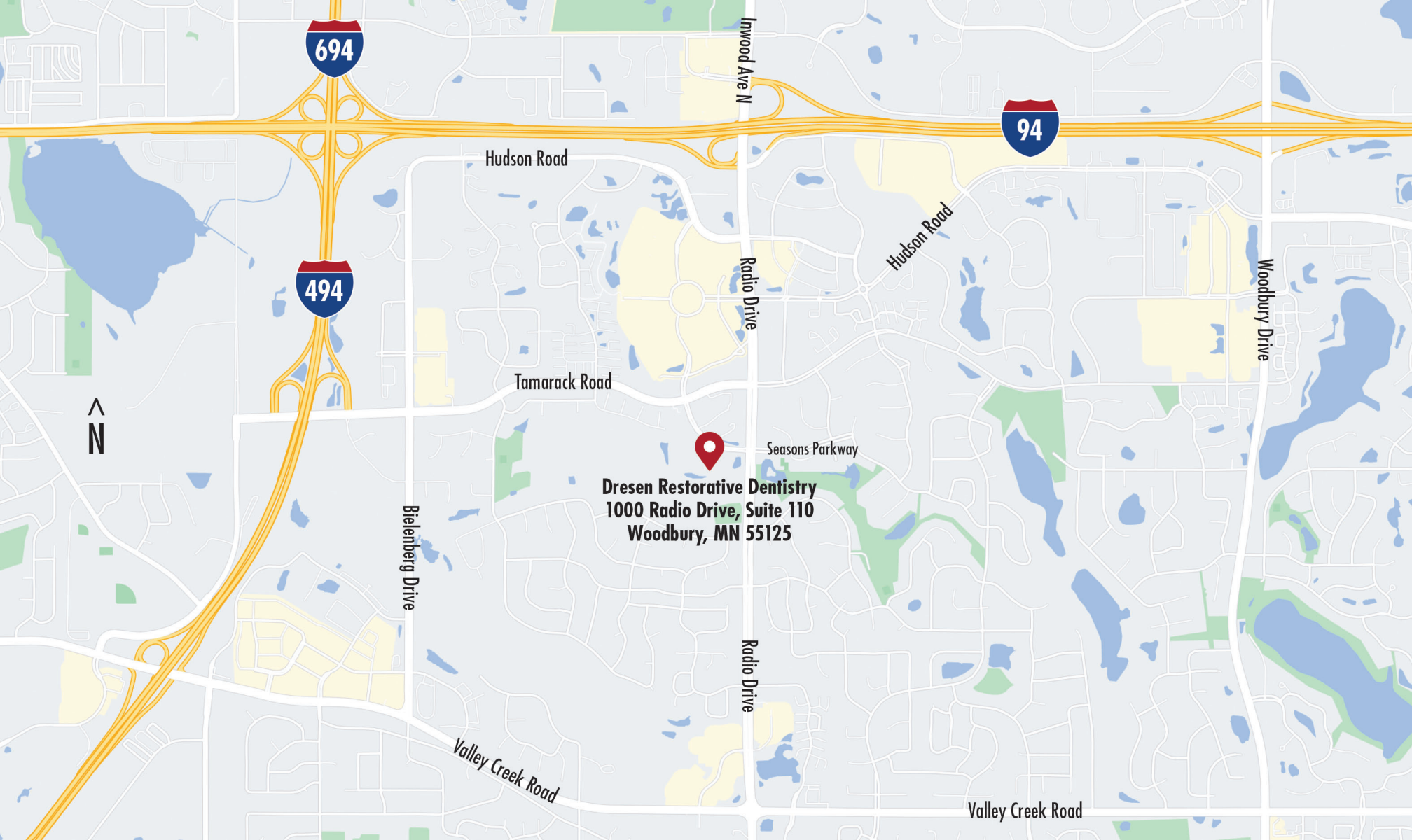
Are you aware if you clench or grind your teeth?  Yes  No

Do you have any sores or lumps in your mouth?  Yes  No

Are you comfortable with dental treatment?  Yes  No

Would you prefer to use Nitrous Oxide gas during treatment?  Yes  No

Is there anything more you would like us to know? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



694

94

494

Inwood Ave N

Hudson Road

Hudson Road

Woodbury Drive

Radio Drive

Tamarack Road

Seasons Parkway

**Dresen Restorative Dentistry**  
1000 Radio Drive, Suite 110  
Woodbury, MN 55125

Bielenberg Drive

Radio Drive

Valley Creek Road

Valley Creek Road

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