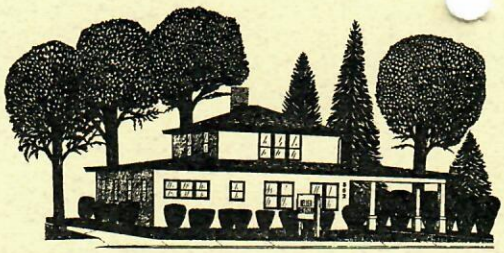

Welcome To Our Practice

John J. Keller D.D.S.
Megan M. Vasko 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 _____

Email _____

Do you want appointment notifications by text / email? Y N

Telephone Home _____

Cell Phone _____ Bus. _____

Social Security No. _____

Patient's Employer Name _____

Present Position _____

How Long Held _____

Spouse / Parent Name _____

Spouse / Parent Employed By _____

Spouse / Parent Phone No. _____

Present Position _____

How Long Held _____

Who is responsible for this account? _____

Method of co-payment: Check____Cash____Credit Card_____

Emergency Contact Name _____

Home # _____ Cell # _____

Relationship _____

Other family Members in this Practice _____

_____

Whom may we thank for the referral _____

DENTAL Primary Coverage

Employee Name _____

Employee Date of Birth _____

Social Security No. _____

Employer Name _____

Insurance Co. Name: _____

Insurance Co. I.D.#. _____

Insurance Co. Phone No. _____

Insurance Co. Address _____

Group / Policy No. _____

Union / Local _____

DENTAL Secondary Coverage

Employee Name _____

Employee Date of Birth _____

Social Security No. _____

Employer Name _____

Insurance Co. Name: _____

Insurance Co. I.D.#. _____

Insurance Co. Phone No. _____

Insurance Co. Address _____

Group / Policy No. _____

Union / Local _____

PATIENT AUTHORIZATION

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

HIPAA - by signing this form, you will consent to our use and disclosure of your health information to carry out treatment, payment activities and health-care operations.

I hereby authorize payment of health insurance benefits directly to the dentist, otherwise payable to me. I understand I am financially responsible for payments in full of all acccounts.

I consent to the use of my x-rays, records and dental photos for scientific publication or teaching providing my name and identity remain anonymous.

Patient or Gaurdian's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ DOB _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ sulfa		
☐ local/topical anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____ ☐ **none**		
3. heart attack, or cardiac stents within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis-joint replacement _____	☐	☐
8. high/low blood pressure _____	☐	☐
9. a stroke (taking blood thinners) _____	☐	☐
10. anemia or other blood disorder _____	☐	☐
11. prolonged bleeding due to a slight cut (INR>3.5) _____	☐	☐
12. emphysema, sarcoidosis _____	☐	☐
13. tuberculosis _____	☐	☐
14. asthma _____	☐	☐
15. breathing or sleep problems (i.e. snoring, sinus) _____	☐	☐
16. kidney disease _____	☐	☐
17. liver disease _____	☐	☐
18. jaundice _____	☐	☐
19. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
20. hormone deficiency _____	☐	☐
21. high cholesterol or taken statin drugs _____	☐	☐
22. diabetes (HbA1c=_____) _____	☐	☐
23. stomach or duodenal ulcer _____	☐	☐
24. digestive disorders (i.e. gastric reflux) _____	☐	☐

	YES	NO
25. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	☐	☐
26. arthritis _____	☐	☐
27. glaucoma _____	☐	☐
28. contact lenses _____	☐	☐
29. head or neck injuries _____	☐	☐
30. epilepsy, convulsions (seizures) _____	☐	☐
31. neurologic problems (attention deficit disorder) _____	☐	☐
32. viral infections and cold sores _____	☐	☐
33. any lumps or swelling in the mouth _____	☐	☐
34. hives, skin rash, hay fever _____	☐	☐
35. venereal disease (STD) _____	☐	☐
36. hepatitis (type___) _____	☐	☐
37. HIV / AIDS _____	☐	☐
38. tumor, abnormal growth _____	☐	☐
39. radiation therapy _____	☐	☐
40. chemotherapy _____	☐	☐
41. psychiatric treatment _____	☐	☐
42. antidepressent medication _____	☐	☐
43. alcohol / drug dependency _____	☐	☐
ARE YOU:		
44. presently being treated for any other illness _____	☐	☐
45. aware of a change in your general health _____	☐	☐
46. taking dietary supplements _____	☐	☐
47. often exhausted or fatigued _____	☐	☐
48. subject to frequent headaches _____ AM / PM _____	☐	☐
49. a smoker or smoked previously _____	☐	☐
50. FEMALE - taking birth control _____	☐	☐
51. FEMALE - pregnant _____	☐	☐
52. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Please provide a current copy of medication list. ☐ **no medications**

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

John J. Keller, DDS

DENTAL HISTORY

How would you rate the condition of your mouth ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist/Clinic_____How long had you been a patient? _____Location: _____

Date of last visit _____/_____/_____ I routinely see my Dentist / Hygienist.: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1-10 (least to most) (____)_____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or your bite adjusted? _____ ☐ ☐
6. Have you had teeth removed? _____ ☐ ☐

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you been disappointed by the appearance of previous dental work? _____ ☐ ☐

BITE AND JAW JOINT

10. Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
11. Do you / would you have any problems chewing gum? _____ ☐ ☐
12. Do you / would you have any problems chewing bagels, protein bars, or other hard foods?_____ ☐ ☐
13. Have your teeth changed in the past 5 years, became shorter, thinner or worn?_____ ☐ ☐
14. Are your teeth crowding or developing spaces?_____ ☐ ☐
15. Do you have more than one bite and squeeze to make your teeth fit together?_____ ☐ ☐
16. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____ ☐ ☐
17. Do you clench your teeth in the daytime or nighttime?_____ ☐ ☐
18. Do you have any problems with sleep or wake up with headaches? _____ ☐ ☐
19. Do you wear or have you ever worn a bite appliance?_____ ☐ ☐

TOOTH STRUCTURE

20. Have you had any cavities within the past 3 years? _____ ☐ ☐
21. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?_ ☐ ☐
22. Do you feel or notice any holes on the biting surface of your teeth? _____ ☐ ☐
23. Are any teeth sensitive to hot, cold, biting, or sweets?_____ ☐ ☐
24. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
25. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
26. Do you get food caught between any teeth? _____ ☐ ☐

GUM AND BONE

27. Do your gums bleed when brushing or flossing? _____ ☐ ☐
28. Have you ever been treated for gum disease or been told you have lost bone around your teeth?_____ ☐ ☐
29. Have you ever noticed an unpleasant taste or odor in your mouth?_____ ☐ ☐
30. Is there anyone with a history of periodontal disease in your family?_____ ☐ ☐
31. Have you ever experienced gum recession? _____ ☐ ☐
32. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐