Dr. John F. Englund D.D.D., P.A.

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name____ Date_____/______/_____
First MI Last

Gender M F (circle one) Birth Date_______/_______/________

Address_______________________________________ City___________________ State________ Zip___________

Email____

Cell phone _______________________________________ Home phone _____________________________________

Preferred method of contact ☐ cell ☐ home ☐ email

Are you: ☐ A Minor ☐ Married ☐ Widowed ☐ Single ☐ Separated

Your or your parent's employer_____________________________________ Occupation______________________

Spouse's or parent's name____

Person to contact in case of emergency___________________________________ phone #_______________________

Insurance Information

Subscribers Name____ is the insured a patient? Yes No

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________________________

Insured's Birth Date_______________________ Subscriber Number/ID #_______________________________

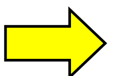
Group #__________________________ Insurance Company Name ___________________________________

Insurance Claims Address____

please bring in card to your appointment or send a picture of the front and the back of the card to info@osseosmiles.com

TURN OVER

Dental History



Former Dentist___________________________________ Reason for today's visit__________________________

Date of last exam_________________________________ Date of last x-rays______________________________

How often do you brush?___________________________ How often do you floss?_________________________

Please check any of the following conditions that apply to you:

☐ Bad Breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding Gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal Treatment	☐ Sensitivity when biting
☐ Food Collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

Health History

Are you under a physician's care now? ☐ Yes ☐ No Why?____

Physicians Name and Address____

Have you been hospitalized in the last two years? ☐ Yes ☐ No Why?_______________________________________

Are you taking any vitamins, medications, pills, or drugs? ☐ Yes or ☐ No Please list or provide list_________________

____

Are you allergic to any medications, substance or latex?____

Do you smoke? ☐ Yes ☐ No **Women**: Are you pregnant? ☐ Yes ☐ No Taking birth control? ☐Yes ☐ No

Please indicate if you have had or have any of the following:

☐Heart Trouble	☐Fainting/Dizziness	☐Frequent Cough	☐Stroke	
☐Lung Disease	☐Glaucoma	☐Heart Murmur	☐Diabetes	☐Cortisone Treatment
☐Epilepsy/Seizures	☐Rheumatic Fever	☐Excessive Thirst	☐Liver Disease	☐Tuberculosis
☐Artificial Joints	☐Hepatitis A or B	☐Hypoglycemia	☐Artificial Heart Valve	☐Extreme Nervousness
☐Yellow Jaundice	☐Psychiatric Care	☐Heart Pacemaker	☐Ulcers	☐Kidney Trouble
☐Cancer	☐Heart Surgery	☐Allergies	☐Thyroid Disease	☐Chemical Dependency
☐Blood Disease	☐Scarlet Fever	☐Hay Fever	☐Hemophilia	☐Blood Transfusion
☐Asthma	☐Chest Pain	☐Sinus Trouble	☐Chemotherapy	☐Anemia
☐Venereal Disease	☐Excessive Bleeding	☐Swelling feet/ankles	☐Arthritis/Gout	☐AIDS or HIV positive
☐Cold Sores	☐Fever Blisters	☐Heart Problems	☐High or Low BP	☐Emphysema
☐Rheumatism	☐Shortness of Breath	☐Parathyroid Disease	☐Congenital Heart Issues	☐Xray/Cobalt Treatment

Have you had any other serious illness not indicated above? Yes No (please list)_____________________________

Is there anything else that would be valuable for us to know? Yes No (please list)_____________________________

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to my behalf or my dependents.

X____

SIGNATURE OF PATIENT (Or Parent if a minor) Date

HIPAA

We may contact you with appointment reminders *including health information* via:
(circle all that apply)

Letters Email Voice Messages Postcards Text

I authorize John Englund, DDS and his staff to release **MEDICAL** information to:

Spouse:____

Parent:____

Other:____

I authorize John Englund, DDS and his staff to release **FINANCIAL** information to:

Spouse:____

Other:____

Patient/Parent/Guardian Signature:____

Date:__________________________

If you wish to change this agreement, you must do so in person or in writing.

If you wish to read our full HIPAA policy, a copy will be provided.

If you feel that your privacy right have been violated by our office, you have the right to file a formal, written complaint.

We will not retaliate against your for filing a complaint.

Contact information:

John F. Englund
Practice Compliance Officer
100 Central Ave Osseo, MN 55369
763-425-8200

Department of Health and Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
Phone: 1-877-696-6775
http://www.HHS.gov