Grace Dental
gentle, caring dentistry

Laurie Stodola, D.D.S. 651 430-1020

Date: _____

Patient Confidential Information

First _____ MI_____ Last _____Birth Date _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____Home Phone _____Email_____

Circle Preferred Contact Means: Phone: *Home *Cell *Work * Email Circle Gender: Male Female

Employer _____ Phone _____

If Student, Name of College _____ City _____ State _____

Name of Parent/Guardian _____ Work Phone _____

Emergency Contact _____ Phone _____

Referred By _____

Name of Previous Dentist _____ Phone _____

Date of Last Exam _____

Responsible Party

Name of Person Responsible for this Account _____

Relationship to Patient _____ Cell Phone _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Email _____ Home Phone _____

Dental Insurance Information

Subscriber Policy Holder _____ Birth Date _____

Employer/Plan Name _____ Group # _____

Relationship to Patient _____ Medical Assistance Program ◯ Yes ◯ No

ID/SSN _____/_____ Insurance Company

_____

Insurance Co. Address _____ Ins. Phone _____

Do you have secondary dental insurance? ◯ Yes ◯ No

Policy Holder _____address _____ Birth Date _____

Employer/Plan Name _____ Group # _____

Relationship to Patient _____ Medical Assistance Program ◯ Yes ◯ No

ID/SSN _____ Insurance Company _____

Laurie Stodola, D.D.S.
12425 55th Street North
Lake Elmo, MN 55042
651.430.1020 Fax 651.439.2201

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____(_self or parent of_____),

have received a copy of this office's Notice of privacy Practices.

Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however acknowledgement could not be obtained due to:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtain acknowledgement

☐ Other (Please Specify)

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Grace Dental to use and disclose Protected Health Information about me to carry out treatment, payment and health care options. (The Notice of Privacy Practices provided by Grace Dental describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Grace Dental reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager.

With this consent, Grace Dental may **CALL my home** or **cell** other alternative location and **leave a message on voice mail** or in person in reference to any items that assist the practice in carrying out treatment plan options, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Grace Dental may **EMAIL to my home or other alternative location** any items that assist the practice in carrying out treatment plan options, such as appointment reminder cards and patient statements. I have the **right to request restrictions** regarding how my Protected Health Information is used or disclosed to carry out treatment plan options. Grace Dental is not required to agree to my requested restrictions, however if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Grace Dental to use and disclose my Protected Health Information to carry out the treatment plan options.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Grace Dental may decline to provide treatment to me.

For adult patients: Please list the names of family members or guardians allowed to discuss your scheduling __treatment __ account items___ with **Grace Dental Staff** .

List allowed persons here:_____

Print Your Name Date

Your Signature or Legal Guardian

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Medical History

Patient Name _____ Birth Date _____

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

Are you under a physician's care now?	Yes	No	If yes, please explain:
Have you ever been hospitalized or had a major operation?	Y	N	If yes, please explain:
Have you ever had a serious head or neck injury?	Y	N	
Do you use controlled substances?	Y	N	List
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Y	N	
Are you on a special diet?	Y	N	Type
Do you use tobacco?	Y	N	Type
Are you taking any medications, pills or drugs?	Y	N	List

For WOMEN only: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Local anesthetics ◯ Acrylic ◯ Metal ◯ Latex ◯ Sulfa Drugs

◯ Other If yes, please explain: _____

Have you had or Do you have any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent weight loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High blood pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High cholesterol	◯ Yes ◯ No	Scarlet fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle cell disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting spells/dizziness	◯ Yes ◯ No	Irregular heartbeat	◯ Yes ◯ No	Sinus trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney problems	◯ Yes ◯ No	Spina bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/intestinal disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low blood pressure	◯ Yes ◯ No	Swelling of limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung disease	◯ Yes ◯ No	Thyroid disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Lyme disease	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart attack/failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Transplant	◯ Yes ◯ No	Pain in jaw joints	◯ Yes ◯ No	Tumors or growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart pacemaker	◯ Yes ◯ No	Parathyroid disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart trouble/disease	◯ Yes ◯ No	Psychiatric care	◯ Yes ◯ No	Venereal disease	◯ Yes ◯ No
Have you ever had any serious illness not listed above?			◯ Yes ◯ No			Yellow jaundice	◯ Yes ◯ No

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge and 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 my child or me during the period of such dental care to third party payors 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 service rendered on my behalf or my dependents.

X Signature _____

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Dental History

Name_____

Reason for today's visit? _____

Is there anything you want to change about your smile? _____

How often do you brush? _____ How often do you floss? _____

Date of last dental visit? _____ Date of last x-rays? _____

Dental concerns…Please check all that apply

◯ Bad Breath	◯ Clicking or popping jaw	◯ Gums swollen or tender	◯ Periodontal treatment
◯ Bleeding gums	◯ Dental anxiety	◯ Jaw pain or tightness	◯ Sensitive to temperatures
◯ Blisters on lips or mouth	◯ Dry mouth	◯ Lip or cheek biting	◯ Sensitive to sweets
◯ Broken fillings or teeth	◯ Fingernail biting	◯ Loose teeth	◯ Sensitive when biting
◯ Burning tongue	◯ Food catching between teeth	◯ Mouth breathing	◯ Sinus problems
◯ Chew on one side of mouth	◯ Foreign objects	◯ Orthodontic treatment	◯ Smoking or chewing
◯ Clenching teeth	◯ Grinding teeth	◯ Pain around ear	◯ Sores or growths

To the best of my knowledge, the questions on this form have been correctly answered. I understand that providing incorrect information can be dangerous to my (or this patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

X

Signature of Patient or Parent/Guardian of Minor Date

Signature Update Date