AccessPoint Dental LLC
1590 S. Robert Street, Suite 120, West St. Paul, MN 55118
(651) 300-0949

Last Name: ___________________________ **First Name**: ___________________________ **MI:**_________ **Title**:_________

Preferred Name: ___________________________ **DOB**: ___________________________ **Sex**: [ ]M [ ]F

Address: __________________________________ **City**: ___________________________ **State**: _________ **Zip**: ________

Cell Phone: ___________________________ **Home Phone**: ___________________________ **SSN**: ____________________

Email: ________________________________ **Employer**: ___________________________

How did you hear about our office?____

Your Relationship to Subscriber: [ ]Self [ ]Spouse [ ]Child

Subscriber Name: ___________________________ Subscriber ID #: ___________________________

Insurance Company: ___________________________ Phone Number: ___________________________

Group Name: ___________________________ Group #:___________________________

PLEASE PRESENT YOUR CARD TO THE FRONT DESK

Your Relationship to Subscriber: [ ]Self [ ]Spouse [ ]Child

Subscriber Name: ___________________________ Subscriber ID #: ___________________________

Insurance Company: ___________________________ Phone Number: ___________________________

Group Name: ___________________________ Group #:___________________________

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to AccessPoint Dental LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize AccessPoint Dental LLC to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ___________________________ **Date**: ___________________________

Relationship: ___________________________

I consent to the diagnostic procedures and treatment by the dentist and staff necessary for proper dental care.

Patient/Guardian Signature:____

Physician Name:_______________________ Physician Phone: _______________________ Last visit date: ___________

List all medications you are currently taking (if none list none):____

____
____

List all medications you are allergic to (if none list none):____

____

List all surgeries you have had (if none list none):____

Select all conditions that you have had or presently have (please check yes or no for each condition):

Y N	Y N	Y N
[ ] [ ] Abnormal Bleeding	[ ] [ ] HIV/AIDS	[ ] [ ] Stroke
[ ] [ ] Alcohol Abuse	[ ] [ ] Heart Attack	[ ] [ ] Thyroid Problems
[ ] [ ] Anemia	[ ] [ ]Heart Surgery	[ ] [ ] Tuberculosis
[ ] [ ] Angina Pectoralis	[ ] [ ] High Blood Pressure	[ ] [ ] Tobacco Use
[ ] [ ] Arthritis	[ ] [ ] Joint Replacement	
[ ] [ ] Artificial Heart Valve	[ ] [ ] Kidney Problems	
[ ] [ ] Asthma	[ ] [ ] Liver Disease	
[ ] [ ] Breathing Problems	[ ] [ ] Mitral Valve Prolapse	If Female:
[ ] [ ] Cancer	[ ] [ ] Pace Maker	[ ] [ ] Are you pregnant?
[ ] [ ] Chemotherapy	[ ] [ ] Psychiatric Problems	[ ] [ ] If yes, how many weeks?
[ ] [ ] Diabetes	[ ] [ ] Radiation Therapy	[ ] [ ] Are you nursing?
[ ] [ ] Drug Abuse	[ ] [ ] Seizures	[ ] [ ] Are you taking birth control Pills?
[ ] [ ] Fainting Spells	[ ] [ ] Sexually Transmitted Disease	

Have you ever taken I.V. Bisphosphonates (Ex. Reclast, Boniva)? [ ]Y [ ]N

Name of Emergency Contact: ____________________________________ Relationship: _________________________

Address:____ Phone:___________________________

Time since last dental visit:_____________________ Unusual reaction to dental injections? [ ]Y [ ]N

Reasons for today's visit: ____

Have you had dental x-rays in the last year? [ ]Y [ ]N

I understand that the information I have given is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status.

Signature:____ **Date**:_____________________________

Please circle any services below you would like our staff to discuss with you during your visit.

Tooth Whitening	Veneers	Invisible Braces
Implants	Mouth Guards	White bonded fillings
Dentures/Partials	Crowns and Bridges	Smile Makeover