GALLERY
DENTAL

Patient Information & Health History

Patient: _____

Date: _____

Dr. Kathrynne Dryke

Cosmetic & Family Dental Care
www.GalleryDentalDuluth.com

230 East Central Entrance
Duluth, MN 55811

Phone: (218) 733-5673
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Dental & Medical Health History

Note: Correct answers to the following questions will allow Dr. Dryke and the Gallery Dental staff to treat you on a more individual basis, providing the care appropriate for your particular needs. It will allow Gallery Dental to treat you so there will not be an emergency. However, if an emergency situation does arise, this information will help insure proper treatment. Your answers are for our records only and will be considered confidential.

Date of Last Dental Visit: _____

How often do you brush your teeth? _____

My brush is… ☐ Soft ☐ Medium ☐ Hard

What other dental aids do you use?

☐ Brush ☐ Dental Floss ☐ Fluoride ☐ Other

Are you having discomfort at this time? ☐ Yes ☐ No

Does dental treatment make you nervous?

☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Place a mark on "yes" or "no" to indicated if you have ever had any of the following…

Mouth

Bleeding, Sore Gums	☐ Yes	☐ No
Unpleasant Taste/Bad Breath	☐ Yes	☐ No
Burning Tongue/Lips	☐ Yes	☐ No
Frequent Blister, Lips/Mouth	☐ Yes	☐ No
Swelling/Lumps in Mouth	☐ Yes	☐ No
Orthodontic Treatments (Braces)	☐ Yes	☐ No
Biting Cheeks/Lips	☐ Yes	☐ No
Clicking/Popping Jaw	☐ Yes	☐ No
Difficulty Opening/Closing Jaw	☐ Yes	☐ No

Teeth

Loose Teeth	☐ Yes	☐ No
Sensitivity to Cold	☐ Yes	☐ No
Sensitivity to Heat	☐ Yes	☐ No
Sensitivity to Sweets	☐ Yes	☐ No
Sensitivity to Biting	☐ Yes	☐ No
Food Impaction	☐ Yes	☐ No
Shifting in Bite	☐ Yes	☐ No
Change in Bite	☐ Yes	☐ No
Clenching/Grinding	☐ Yes	☐ No

If so, when: _____

What do you fear most about dental care?

These things are important to me about my dental health…

Have you ever had any serious trouble associated with previous dentistry? ☐ Yes ☐ No

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ☐ Yes ☐ No

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

If yes, for what? _____

Physician's Name: _____

Last Visit to Physician: _____

Do you have high blood pressure? ☐ Yes ☐ No

If yes, what is it? _____

Do you use tobacco? ☐ Chew ☐ Smoke

How often? _____ How long? _____

Do you consume alcohol? ☐ Yes ☐ No

How many beverages per week? _____

Do you use any mood altering drugs other than those previously listed? ☐ Yes ☐ No

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Are you allergic or have you had a reaction to the following…

Local Anesthetic	☐ Yes	☐ No
Penicillin or Other Antibiotics	☐ Yes	☐ No
Aspirin, Ibuprofen or Tylenol	☐ Yes	☐ No
Codeine, Valium® or Other Sedatives	☐ Yes	☐ No
Latex or Metals	☐ Yes	☐ No

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? ☐ Yes ☐ No

If yes, please list: _____

Are you currently taking any medications, drugs or pills?

☐ Yes ☐ No

If yes, please list name and dosage: _____

Check yes or no to indicate whether or not you have had or now have the following conditions or treatments:

Heart Condition	☐ Yes	☐ No	Contact Lenses	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Arthritis/Rheumatism	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No	Fen-Phen or Redox	☐ Yes	☐ No
Chest Pain (Angina)	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Special or Restricted Diet	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Chronic Cough	☐ Yes	☐ No	Latex Sensitivity	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Tuberculosis (T.B.)	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Allergies or Hives	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Nervous/Anxious	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	AIDS	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No	Artificial Joints or Heart Valves	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Family History of Diabetes	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Bone Disease or Bone Cancer	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Swollen Ankles	☐ Yes	☐ No			

Any disease, condition or problem not listed: _____

Women

Are you pregnant or planning a pregnancy? ☐ Yes ☐ No

If yes, due date: _____

Are you a nursing mother? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Patient Information

GALLERY DENTAL

Patient

Last: _____ First: _____

Middle Initial: _____ Preferred: _____

Gender: ☐ Male ☐ Female

Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Work: _____

Cell: _____

Email: _____

Parent/Guardian: _____

Insurance

Subscriber's Name: _____

Relationship: _____ Date of Birth: _____

Subscriber Id #: _____

Employer: _____

Insurance Company: _____

Group #: _____

Address: _____

City: _____ State: _____ Zip: _____

Dual Coverage: ☐ Yes ☐ No *If yes please complete the following*

Subscriber's Name: _____

Relationship: _____ Date of Birth: _____

Subscriber Id #: _____

Employer: _____

Insurance Company: _____

Group #: _____

Address: _____

City: _____ State: _____ Zip: _____

Employment/School

Occupation: _____

Employer/School: _____

Spouse's name: _____

Employer: _____

Emergency Notification

Name: _____

Relationship: _____

Phone: _____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treament or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor. I attest to the accuracy of the information on this page.

Photo Release

I consent to the taking of radiographs and/or photographs before and during treatment for diagnosis purposes, for use in papers, demonstrations, teaching materials, marketing, advertising and Gallery Dental's website. I also understand that the radiographs and/or photographs may be released to other health care providers or insurance carriers for my benefit.

☐ Yes ☐ X-Rays Only

_____

Signature of Patient or Guardian

_____

Date

Referral Information

How did you learn about us? _____

GALLERY DENTAL'S OFFICE & FINANCIAL POLICIES

Thank you for choosing Gallery Dental. We are committed to providing you with the best possible dental care. The following information describes our Office & Financial Policies.

NO INSURANCE

Payment is due at the time services are rendered. We accept cash, check, and all major credit cards.

INSURANCE

Your estimated co-payment and deductible is due at the time services are rendered. After submitting your claim and receiving remittance from insurance, any balance not covered by insurance will be billed to you for payment due.

- Your insurance policy is a contract between you and the insurance company. We are not a party to that contract. Our financial relationship is with you, not your insurance company.
- All charges are your responsibility whether your insurance company pays or not. **Not all services are covered benefits in all contracts and insurance is not a guarantee of coverage or payment.**
- We will help you process your insurance claim for reimbursement as long as we have complete insurance information.

FINANCING

Interest-free financing is available thru CareCredit or Lending Club. You are subject to credit approval. Please inquire at the front desk for details.

RELEASE OF INFORMATION TO INSURERS AND ASSIGNMENT OF BENEFITS

To the extent permitted by law, I consent to my practices use and disclosure of my Protected Health Information to carry our payment activities in connection with my insurance plan. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature **Print Name** **Date**

NOTICE OF PRIVACY PRACTICES (HIPPA)

By signing below, I acknowledge that I have read the Notice of Privacy Practice, as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature **Print Name** **Date**

APPOINTMENTS

Your appointment time is reserved especially for you. Please help us serve you and our other patients better by keeping all scheduled appointments and arriving on time. We ask for a 24 hours notice for any change of appointment.