



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
Fax: (218) 733-5674
staff@GalleryDentalDuluth.com

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

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

Any disease, condition or problem not listed: _____

Women

Are you pregnant or planning a pregnancy? Yes No Are you a nursing mother? Yes No

If yes, due date: _____ Are you taking birth control pills? Yes No

Patient Information



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 treatment 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
Dr. Kathrynne Dryke
230 E Central Entrance
Duluth, MN 55811
218.733.5673

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. Please initial before each statement and sign and date indicating that you have read and understand our 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

CareCredit is available for financing any portion of your balance. CareCredit offers 6, 12, and 18 month interest-free plans. You are subject to credit approval. Please contact CareCredit at (800)677-0718 or www.carecredit.com or inquire at the front desk details.

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 24 hours notice for any change of appointment.

Thank you for taking time to read and understand our Office & Financial Policies. Please let us know if you have any questions regarding your treatment or your financial responsibilities. We will be glad to review them with you at any time.

Signature

Print Name

Date