MINNESOTA STATE UNIVERSITY DENTAL CLINIC

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120 CLINICAL SCIENCES BLDG. | 150 SOUTH ROAD • MANKATO, MN 56001 (507)389-2147

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice? If referred by a dental office or student, please list the name:

Referral Name: _____

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact:

Responsible Party Information:

This only needs to be completed if the insurance subscriber is someone other than the patient, or you are the parent/guardian of the patient.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Do you have dental (not medical) insurance? Please ensure your card lists dental as a benefit. ◯ Yes ◯ No

Primary Dental Insurance:
(Leave blank if none)

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Insurance Company Phone Number:

Secondary Dental Insurance:
(Leave blank if none)

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

Address 1 Address 2

_____ _____ _____-____

City State Zip Code

Secondary Insurance Company Phone Number:

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

What is your immediate concern about your dental health?

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

I routinely see a dentist every

☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

Check all that apply:

☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ You experience dry mouth
☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Have you ever whitened or bleached your teeth
☐ Have you experienced popping and/or clicking of your jaw joint
☐ You have difficulty chewing
☐ You have difficulty opening or closing your jaw
☐ You clench or grind your teeth
☐ You wear or have worn a bite appliance
☐ Gums bleed when brushing or flossing
☐ Sores, lumps or ulcers in your mouth
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Noticed an unpleasant taste or odor in your mouth
☐ Biting of lips or cheeks frequently
☐ Dental Implants
☐ Partials/Dentures
☐ You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe: