ROGER M. AMUNDSON, DDS, MAGD
2600 DeMers Avenue • Grand Forks, ND 58201 • (701) 772-0171
www.rogeramundsondds.com

PATIENT REGISTRATION

Patient _____
Last Name **First Name** **Initial** **Preferred Name**
Street Address_____**City**_____**State**_____**Zip**_____

Sex: ___M ___F Age_____ Birthdate_____ Single _____Married _____Widowed _____Divorced _____

E-mail address_____**Cell Phone**_____**Home phone**_____

Employed by_____ **Occupation**_____**Business Phone**_____

Spouse Name_____**Spouse Birthdate**_____**Spouse Employment**_____ **Occupation**_____

Who is responsible for this account?_____ **Relationship to Patient**_____

Social Security # _____**Spouse's Social Security #** _____

Name of Dental Insurance Company_____ **Group Number**_____ **Insured ID** _____

In case of emergency, who should be notified? _____**Phone**_____

Who may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name_____ **Date of last physical**_____
Have you ever had any of the following? (Check boxes that apply):

____Heart Problems
____High Blood Pressure
____Low Blood Pressure
____Circulatory Problems
____Nervous Problems
____Radiation Treatment
____Artificial Heart Valves or Joints
____Recent Weight Loss
____Back Problems
____Diabetes
____Respiratory Disease
____Epilepsy
____Headaches
____Hepatitis, Jaundice or Liver Disease
____Cancer
____Psychiatric Care
____Chronic Diarrhea
____Allergies to Anesthetics
____Allergies to Medicines or Drugs
____General Allergies
____Blood Disease
____Arthritis
____Special Diet
____Swollen Neck Glands
____Rheumatic Fever
____Sinus Problems
____A.I.D.S. or other Immunosuppressive Disorders
____Stroke
____Ulcer
____Venereal Disease
____Chemical Dependency
____Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what?
_____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medications at this time? ____If so, what?_____

Are you under the care of a physician? ____Yes____ No For what conditions?_____

(Woman) Do you suspect that you are pregnant? ____Yes____No Are you nursing? ___Yes___No

Is there anything else we should know about your medical history? _____
The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____**Signature**_____

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DENTAL QUESTIONAIRE

Patient _____
Last Name **First Name** **Initial** **Preferred Name**

What is the reason for your visit today?_____

Please fill in the yes or no to the following questions:

____ Yes ____ No Are you having PAIN, SWELLING, or SORE SPOTS at this time?

____ Yes ____ No Do your GUMS BLEED?

____ Yes ____ No Have you had GUM TREATMENTS?

____ Yes ____ No If you SNORE, would you like an oral device to help you stop snoring?

____ Yes ____ No Do you have BAD BREATH?

____ Yes ____ No Is this your FIRST VISIT to any dentist?

____ Yes ____ No Have you had COMPLICATIONS with dental treatment?

____ Yes ____ No Have you been treated for TMJ (Temporomandibular Joint) problems?

____ Yes ____ No Do you have REMOVABLE dentures or partials? Upper_____Lower_____

____ Yes ____ No Do you have a FEAR of Dentistry? If yes, why?_____

____ Yes ____ No Do you like your SMILE?

____ Yes ____ No Have you had a complete set of X-RAYS taken in the past 3 years? If yes, where?_____

____ Yes ____ No Is your WATER FLUORIDATED?

____ Yes ____ No Have you visited our website www.rogeramundsondds.com?

When was your last dental visit_____

If you could change anything about your smile/teeth, what would that change be?_____

	Poor				Average					Excellent
Where do you rate your current level of dental health?	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
Where would you like it to be?	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10

Is there anything else we should know about your dental history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

I hereby authorize ROGER M AMUNDSON DDS to administer dental treatment and local anesthetic and to perform procedures deemed necessary in the diagnosis and dental treatment of the above named patient.

I agree to pay for all professional fees and treatments, or my portion not covered by dental insurance, for myself, or the above mentioned patient, unless other financial arrangements are approved.

Date_____**Signature**_____
Patient or Financially Responsible Party