

Welcome to our office!

We appreciate your confidence and take great pride in providing high quality dental care for our patients. Below are our office hours and location. Also, you will find a registration, health history, records transfer and release forms. **Please complete the provided forms prior to your appointment and bring these, as well as your insurance information (if applicable).**

Our Office Hours are:	Dr. Kristi O’Kane	Dr. Brian Monssen
Monday	7.00 a.m. to 3:30 p.m.	8:00 a.m. to 5:00 p.m.
Tuesday	7.00 a.m. to 3:00 p.m.	8:00 a.m. to 5:00 p.m.
Wednesday	7.00 a.m. to 3:30 p.m.	8:00 a.m. to 5:00 p.m.
Thursday	7.00 a.m. to 3:00 p.m.	8:00 a.m. to 5:00 p.m.
We are closed on Fridays		

Our office is located across from the Ford Plant one block west of Cretin Ave. We are in the Haskell’s building on the second floor.

Please call if we can be of further assistance. 651/698-1242

We look forward to meeting you!

Drs. Kristi O’Kane and Brian Monssen

MEDICAL HISTORY

Date _____

Patient's Name _____ Birthdate _____

Name of your medical doctor _____ Medical doctor's telephone _____

Address of your medical doctor _____

Name of person we may contact in case of emergency _____

Name _____ Telephone _____

Relationship to you _____ Cell phone _____

Circle definite answer to each question.

Yes No Any changes in your health in the past two years?

Yes No Are you currently under the care of a physician?

If yes, describe your treatment: _____

Yes No Have you had medical treatment or physician visit of any kind during the past two years?

If yes, describe: _____

Yes No Have you had any major surgical operation of any kind?

If yes, describe: _____

Yes No Were you transfused?

Do you have, have you had or are you being treated for any of the following?

Circle a definite answer to each question.

- | | | | | | |
|-----|----|-------------------------|-----|----|-------------------------------|
| Yes | No | Arthritis | Yes | No | Heart murmur |
| Yes | No | Chronic diarrhea | Yes | No | Anemia, sickle cell disease |
| Yes | No | Glaucoma | Yes | No | Herpes II |
| Yes | No | High blood pressure | Yes | No | Allergies |
| Yes | No | Mitral valve prolapse | Yes | No | HIV positive |
| Yes | No | Thyroid condition | Yes | No | Acquired immune deficiency |
| Yes | No | Venereal disease | Yes | No | Anorexia, bulimia |
| Yes | No | Jaundice | Yes | No | Radiation therapy |
| Yes | No | Ear infections | Yes | No | Pacemaker, Type _____ |
| Yes | No | Chronic sinus | Yes | No | Hip/joint replacement |
| Yes | No | Hemophilia | Yes | No | Enzyme deficiency (i.e. G6PD) |
| Yes | No | Cancer | Yes | No | Hepatitis, Type _____ |
| Yes | No | Asthma | Yes | No | Ulcers |
| Yes | No | Kidney disorder | Yes | No | Chemotherapy |
| Yes | No | Seizures | Yes | No | Tuberculosis/lung disease |
| Yes | No | Hay fever | Yes | No | Excessive/prolonged bleeding |
| Yes | No | Stroke | Yes | No | Blood disorder |
| Yes | No | Psychiatric care | Yes | No | Chemical/alcohol dependant |
| Yes | No | Congenital heart defect | Yes | No | Rheumatic fever |
| Yes | No | Low blood pressure | Yes | No | Heart surgery |
| Yes | No | Epilepsy | Yes | No | Fainting spells |
| Yes | No | Diabetes | Yes | No | Hypothermia |
| Yes | No | Emphysema | Yes | No | Headaches |

Yes No Have you had an allergic reaction or been told not to take any medication?

If yes, describe: _____

Yes No Are you currently taking prescription medication of any kind? (i.e: birth control, hormones, diet).

If yes, please list: _____

Yes No Are you currently taking non-prescription drugs of any kind? (i.e: aspirin, cough syrup, caffeine, nasal spray, recreational drug) If yes, please list: _____

Yes No Are you pregnant? If yes, anticipated delivery date: _____

Yes No Do you use any tobacco product? If yes, type of product and daily intake: _____

Yes No Do you wear contact lenses?

I certify the above to be true to the best of my knowledge.

Patient's Signature _____ Date _____

Recorded By: _____ D.D.S. signature _____

RECORDS RELEASE FORM

I, _____, authorize my records released to:

**Drs. O'kane & Monssen, DDS
2221 Ford Pkwy.
Suite 201
St. Paul, Mn. 55116**

Patient/Guardian Signature

Date

Please forward the most current FMX, Pano and BWX, regardless of the date of service it was done. Thank You.