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. to5:00 p.m.
Tuesday	7.00 a.m. to 3:00 p.m.	8:00 a.m. to5:00 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 futher assistance. 651/698-1242

We look forward to meeting you!

Drs. Kristi O'Kane and Brian Monssen

Thank you for selecting us

To help us meet your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help you.

Welcome!!

Patient Information (confidential)
Date___________________________

Name____ **Sex: M**____**F**___
Last **First** **MI**
Date of Birth_________________**Age**______**Social Security Number**____________________________________

Parent or Guardian (if minor)____

Address__________________________________**City**_________________________**State**_________**Zip**________

Home Phone______________________**Work Phone**_______________________**Cell Phone**___________________

Email Address____

Marital Status: S___ **M**___ **D**___ **W**___
If student, Name of School/College______________________________**City**_____________ **FT**___ **PT**___
Employer__________________________________ **Occupation**____
Emergency Contact__________________________ **Phone#**___________________________________
Whom may we thank for referring you? (check one) Friend/Relative___ **Name** _____________________________
Yellow pages___ **Other** ___ **Name**__________________________

Responsible Party (If other than yourself)
Name of person responsible for this account______________________________ **Relationship**_________________
Address if different than above__________________________________**City**_____________**State**____**Zip**_______
Employer Name___________________________**Address**____
Home Phone______________________**Work Phone**_____________________**Cell Phone**____________________
Date of Birth__________________**Social Security Number**_________________________________

Dental Insurance Information
Primary Dental Insurance Coverage (insurance name)____
ID Number_________________________________**Group/Account Number**________________________________
Policy Holder_______________________________**Relationship to Patient**________________________________
Employer Name_____________________________
Secondary Dental Insurance Coverage (insurance name)____
ID Number_________________________________**Group/Account Number**________________________________
Policy Holder_______________________________**Relationship to Patient**________________________________
Employer Name_____________________________

I authorize the release of any medical/dental information as required by my insurance company. I also authorize payment of dental benefits to be made directly to O'Kane and Monssen, DDS. <u>I agree to pay any or all charges that exceed or that are not covered by my insurance.</u>

Signature____**Date**____________________

PLEASE SUBMIT INSURANCE CARD TO RECEPTIONIST

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	Arthiritis	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,bullemia
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 ______________________

Please complete this form and mail or fax it to your previous dentist prior to your appointment

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.

Name of your previous dentist____________________________________

Telephone number of your previous dentist_________________________