**Lindstrom Family Dentistry LLC**
**Matthew Struve, D.D.S.**

12245 Lindstrom Ln.
Lindstrom, MN 55045
(651)257-4471

## PATIENT INFORMATION

Today's Date ______________

Name ____________________________________________ Nickname ____________________

Age _________ Birthdate ___________________ Marital Status ________________ Male ____ Female ____

Social Security # ____________________________________________________________

Address ________________________________________ City _____________ Zip Code ___________

Home Phone ___________________________ Cell Phone _____________________________

Employed By __________________________What is the best way to contact you? (Circle one) Text Email Call

Email Address____________________________________________________________

Whom may we thank for referring you ____________________________________________

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Spouse's Name ________________________________ Birthdate ____________ Social Security # __________________

Cell Phone _______________________ Spouse Employed By ____________________________________

Email Address____________________________________________________________

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Emergency Contact Name ______________________________________ Relationship ___________________

Address ______________________________________________________ Phone # __________________

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Former Dentist ________________________________________ Phone # ____________________

### FINANCIAL INFORMATION

Person responsible for this account _____________________________ Relationship to patient ________________________

Phone # _________________ Address __________________________________________________

### TERMS AND CONDITIONS

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms to assist in making collections from insurance companies and will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. In some cases a credit report may be obtained.

I have read the above conditions of treatment and agree to their contents.

**SIGNED** ____________________________________________________ **DATE** ___________________

**CONSENT FOR TREATMENT:**

I hereby grant authority to Dr. Struve to administer treatment; or to administer such anesthetics, analgesics and sedatives; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of possible complications of the procedures, anesthetics, and/or drugs.

Signed ___________________________________________________ Date ___________________

Authorization must be signed by patient, or nearest relative in the case of a minor or when patient is physically or mentally incompetent.

Relationship to patient ______________________________________

5/1/17