Patient Information

First Name:_____ Last Name: _____ Middle Initial: ___

Preferred Name:_____

Address: _____ Address 2: _____

City: _____ State/ ZIP: _____

Cell Phone: _____ Other Phone: _____

Sex: ◯ Male ◯ Female Marital status: ◯ Single ◯ Married ◯ Divorced

Birthdate: _____ Age: _____ Social Security Number: _____

Email: _____

Business Name/ Employer: _____

Responsible Party *(If different than above)*

First Name: _____ Last Name: _____ Middle Initial: ___

Address: _____ Address 2: _____

City: _____ State/ ZIP: _____

Cell Phone: _____ Other Phone: _____

Birthdate: _____ Age: _____ Social Security Number: _____

Primary Insurance Information ◯ No insurance Patient is: ◯ Policy Holder ◯ Responsible Party

Employer: _____ Insurance Company: _____

ID Number or SSN:_____ Group Number: _____

Dental History

Reason for today's visit: _____

When were you last seen by a dentist?_____

Is there anything about your smile or teeth you would like to change? _____

How did you hear about our office? _____

Do you have any of the following symptoms in your mouth?

◯ Bad Breath ◯ Grinding Teeth ◯ Bleeding Gums ◯ Noise/ Pain in Jaw ◯ Broken Teeth

◯ Sores in Mouth ◯ Loose Teeth ◯ Sensitive to Sweets ◯ Sensitive to Biting ◯ Sensitive to Cold

Have you ever had periodontal (gum disease) treatment? If so, please explain: _____

_____

Other dental problems/ concerns:_____

_____

Medical History Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important inter-relationship with the dentistry you will receive. Thank you for answering the following questions. →

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you been recently hospitalized? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications or drugs? ◯ Yes ◯ No If yes, please list: _____

Do you take, or have you taken Phen-Fen or Redux? ◯ Yes ◯ No _____

Fosamax, Boniva, Actonel, or bisphosphonate use? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No _____

Do you use controlled substances? ◯ Yes ◯ No _____

(Women): Are you: ◯ Pregnant/Trying to get pregnant? ◯ Taking birth control pills? ◯ Nursing?

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Local Anesthetic ◯ Acrylic ◯ Metal ◯ Latex ◯ Sulfa Drugs

◯ Other Please explain: _____

Check if you have or have had any of the following:

◯ AIDS/ HIV Positive
◯ Alzheimer's
◯ Anaphylaxis
◯ Anemia
◯ Angina
◯ Arthritis/ Gout
◯ Artificial Heart Valve
◯ Artificial Joint
◯ Asthma
◯ Blood Disease
◯ Blood Transfusion
◯ Breathing Problem
◯ Bruise Easily
◯ Cancer
◯ Chemotherapy
◯ Chest Pains
◯ Cold Sores
◯ Congenital Heart Disorder
◯ Convulsions
◯ Cortisone Medicine
◯ Diabetes
◯ Drug Addiction
◯ Easily Winded
◯ Emphysema
◯ Epilepsy/ Seizures
◯ Excessive Bleeding
◯ Excessive Thirst
◯ Fainting/ Dizziness
◯ Frequent Cough
◯ Frequent Diarrhea
◯ Frequent Headaches
◯ Genital Herpes
◯ Glaucoma
◯ Hay Fever
◯ Heart Attack/ Failure
◯ Heart Murmur
◯ Heart Pacemaker
◯ Heart Trouble/ Disease
◯ Hemophilia
◯ Hepatitis A
◯ Hepatitis B or C
◯ Herpes
◯ High Blood Pressure
◯ Hives or Rash
◯ Hypoglycemia
◯ Irregular Heartbeat
◯ Kidney Problems
◯ Leukemia
◯ Liver Disease
◯ Low Blood Pressure
◯ Lung Disease
◯ Mitral valve Prolapse
◯ Osteoporosis
◯ Pain in Jaw Joints
◯ Parathyroid Disease
◯ Psychiatric Care
◯ Radiation Treatments
◯ Recent Weight Loss
◯ Renal Dialysis
◯ Rheumatic Fever
◯ Rheumatism
◯ Scarlet Fever
◯ Shingles
◯ Sickle Cell Disease
◯ Sinus Trouble
◯ Spina Bifida
◯ Stomach Disease
◯ Stroke
◯ Swelling of Limbs
◯ Thyroid Disease
◯ Tonsillitis
◯ Tuberculosis
◯ Tumors or Growths
◯ Ulcers
◯ Venereal Disease
◯ Yellow Jaundice

Any serious illness not listed above/comments: _____

_____

_____

_____

Consent for Treatment & HIPAA

I give my consent for Dr. Crumbaugh and her office staff to do a complete and thorough examination on the patient previously named, including any photographs, study models, needed radiographs, or other diagnostic aids. To the best of my knowledge, the information I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to notify Dr. Crumbaugh of any future changes to the patient's medical status. I do hereby grant Dr. Crumbaugh and her staff permission to perform any needed treatment(s). Furthermore, I have been offered a copy of Dr. Crumbaugh's Privacy Policy. _____ (*Initial)*

Requirement for Filing Insurance Claims

To precipitate the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I hereby authorize payment of insurance benefits directly to Dr. Crumbaugh. I also authorize the use of this signature on all insurance submissions.

_____ (*Initial)*

Patient Signature: _____ Date: _____

Parent or Responsible Party (if different than above): _____

Relationship to Patient: _____