Welcome to Crosby Dental Group

PATIENT INFORMATION **DATE** _____

NAME _____

ADDRESS _____

(STREET) (APT#) (CITY) (STATE) (ZIP)

HOME PHONE NUMBER ( ) _____ OFFICE PHONE NUMBER ( ) _____

EMAIL ADDRESS _____ CELL NUMBER ( ) _____

DATE OF BIRTH _____ PLACE OF BIRTH _____ SEX ____ MARITAL STATUS _____

PATIENT'S SOCIAL SECURITY NUMBER _____

PATIENT'S EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____

PERSON RESPONSIBLE FOR PATIENT ACCOUNT _____

ADDRESS _____ PHONE NUMBER ( ) _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

IF PATIENT IS A CHILD MOM'S NAME _____ FATHER'S _____

HOW DOES THE RESPONSIBLE PERSON PLAN TO PAY FOR THE DENTAL CARE PATIENT RECEIVES HERE: (CIRCLE BELOW)

CASH/CHECK PAYMENT

CREDIT CARD

DENTAL INSURANCE

CARE CREDIT

	PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
NAME OF COMPANY	_____	_____
POLICY HOLDER	_____	_____
POLICY HOLDER SS#	_____	_____
POLICY HOLDER D/O/B	_____	_____
EMPLOYER	_____	_____

WHO REFERRED YOU TO OUR CLINIC? _____

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY? _____

PHONE NUMBER ( ) _____

*PLEASE BE AWARE THAT PAYMENT FOR FIRST VISIT WILL BE REQUIRED AT TIME OF VISIT OUR OFFICE WILL BE HAPPY TO ASSIST IN FILING INSURANCE ON FOLLOWING VISITS.

HEALTH HISTORY QUESTIONAIRE **DATE** _____

1. ARE YOU UNDER THE CARE OF A PHYSICIAN? IF SO, WHAT IS THE CONDITION BEING TREATED? _____

2. THE NAME AND ADDRESS OF MY PHYSICIAN _____

_____

_____

3. HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATION RECENTLY? IF SO, WHAT WAS THE ILLNESS OR OPERATION? _____

4. DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?	YES	NO
A. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE	( )	( )
B. CONGENITAL HEART LESIONS (HEART MURMUR)	( )	( )
C. CARDIOVASCULAR DISEASE (HEART TROUBLE, CORONARY INSUFFICIENCY, CORONARY OCCLUSION, PACEMAKER, HEART VALVE REPLACEMENT)	( )	( )
D. MITRAL VALVE PROLAPSE	( )	( )
E. PROSTHETIC JOINTS, IMPLANTS, ETC.	( )	( )
F. ALLERGY	( )	( )
G. ASTHMA OR BREATHING DISORDER	( )	( )
H. FAINTING SPELL OR SEIZURES	( )	( )
I. DIABETES	( )	( )
J. HEPATITIS, JAUNDICE OR LIVER DISEASE	( )	( )
K. ARTHRITIS	( )	( )
L. GASTRIC REFLUX	( )	( )
M. KIDNEY TROUBLE	( )	( )
N. TUBERCULOSIS	( )	( )
O. HIGH OR LOW BLOOD PRESSURE	( )	( )
P. IMMUNE SYSTEM DISORDER (INCLUDING AIDS, HIV)	( )	( )
Q. SJOGREN'S SYNDROME	( )	( )
R. OSTEOPOROSIS	( )	( )

5. HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS EXTRACTIONS, SURGERY, OR TRAUMA?	( )	( )
6. DO YOU HAVE ANY BLOOD DISORDER SUCH AS ANEMIA OR HEMOPHILIA?	( )	( )
7. HAVE YOU HAD SURGERY OR XRAY TREATMENT FOR A TUMOR, GROWTH, OR OTHER CONDITION OF YOU MOUTH OR LIP?	( )	( )
8. ARE YOU TAKING ANY DRUG OR MEDICINE WHATSOEVER? LIST: _____	( )	( )
9. ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO LOCAL ANESTHETICS OR ANY MEDICATION? LIST: _____	( )	( )
10. HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT?	( )	( )
11. DO YOU USE TOBACCO?	( )	( )

DATE _____ **YES** **NO**

12. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE I SHOULD KNOW ABOUT? ( ) ( )

13. WOMEN - ARE YOU PREGNANT ( ) ( )

14. DO YOU HAVE ANY OF THE FOLLOWING? OR HAVE YOU EVER HAD?

MOUTH	**YES**	**NO**		**YES**	**NO**
BLEEDING, SORE GUMS	( )	( )	LOOSE TEETH	( )	( )
UNPLEASANT BAD BREATH	( )	( )	SENSITIVE TO HOT	( )	( )
FREQUENT BLISTER MOUTH/LIPS	( )	( )	SENSITIVE TO COLD	( )	( )
SWELLING/LUMPS IN MOUTH	( )	( )	SENSITIVE TO BITING	( )	( )
BITING CHEEKS/LIPS	( )	( )	CLENCHING/GRINDING	( )	( )
CLICKING/POPPING JAW	( )	( )	IF SO, WHEN		
SHIFTING IN BITE	( )	( )	CHANGE IN BITE	( )	( )

15. ARE YOU PLEASED WITH THE APPEARANCE OF YOUR TEETH AND SMILE? ( ) ( )
IF NOT, WHAT WOULD YOU LIKE TO CHANGE ABOUT THE APPEARANCE?

_____

16. LAST DENTAL EXAM _____ LAST DENTAL X RAYS _____

IF YOU ARE COMPLETING THIS FORM FOR ANOTHER PERSON, WHAT IS YOUR RELATIONSHIP?

_____

TO MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE A CHANGE IN MY HEALTH OR CHANGE IN MY MEDICATION, I WILL INFORM THE DENTIST AT MY NEXT APPOINTMENT.

_____ _____

SIGNATURE OF PATIENT DATE SIGNATURE OF DENTIST DATE