CRYSTAL FALLS DENTAL

FAMILY AND COSMETIC DENTISTRY

Date: _____

Medical History

Patient Name: _____ Birthdate: _____
First Last

Primary Physician: _____ Phone # _____

Please list any medications you are currently taking:

Med 1: _____ Med 2: _____ Med 3: _____ Med 4: _____

Med 5: _____ Med 6: _____ Med 7: _____ Med 8: _____

Check Yes or No to the following questions:

1. Are you presently under the care of a physician? ☐ Yes ☐ No
2. Have you ever had high/low blood pressure? ☐ Yes ☐ No
3. Has a physician ever said you had heart trouble? (ex: Artificial heart valve, Heart attack, Pace maker, Angina Pectoris) ☐ Yes ☐ No
4. Do you have Mitral Valve Prolapse or Congenital Heart Defect? ☐ Yes ☐ No
5. Have you ever had abnormal bleeding following a cut or extraction? ☐ Yes ☐ No
6. Have you ever had an anesthetic (either local or general)? ☐ Yes ☐ No
7. Has a physician or dentist ever said you had a tumor or cancer? ☐ Yes ☐ No
8. Are you taking any osteoporosis medications? ☐ Yes ☐ No
9. Are you allergic to Penicillin, Novocain or any other medicine? ☐ Yes ☐ No
   If so, what? _____
10. Is the patient allergic to anything other than medicine? (e.g. latex or metals)? ☐ Yes ☐ No
    If so, what? _____

Do you have or ever had:

1. Rheumatic fever? ☐ Yes ☐ No
2. Rheumatic heart disease? ☐ Yes ☐ No
3. Anemia, leukemia or low platelets? ☐ Yes ☐ No
4. Epilepsy or convulsions? ☐ Yes ☐ No
5. Asthma or hay fever? ☐ Yes ☐ No
6. Tuberculosis? ☐ Yes ☐ No
7. Diabetes? ..... How long _____ ☐ Yes ☐ No
8. Kidney trouble? ☐ Yes ☐ No
9. Liver trouble or jaundice? ☐ Yes ☐ No
10. Thyroid trouble or goiter? ☐ Yes ☐ No
11. Syphilis? ☐ Yes ☐ No
12. Fainting or dizziness? ☐ Yes ☐ No
13. Glaucoma? ☐ Yes ☐ No
14. Arthritis? ☐ Yes ☐ No
15. HIV AIDS? ☐ Yes ☐ No
16. Stroke? ☐ Yes ☐ No
17. Stomach ulcer? ☐ Yes ☐ No
18. Heart murmur? ☐ Yes ☐ No
19. Prostate trouble? ☐ Yes ☐ No
20. Hepatitis A, B, C or D? ☐ Yes ☐ No
21. Eczema or hives? ☐ Yes ☐ No
22. Psychiatric treatment? ☐ Yes ☐ No
23. Are you pregnant? .. How many months_____ ☐ Yes ☐ No
24. Alcohol abuse? ☐ Yes ☐ No
25. Recreational Drug use? ☐ Yes ☐ No
26. Blood Transfusion? ☐ Yes ☐ No
27. Emphysema? ☐ Yes ☐ No
28. Frequent Headaches? ☐ Yes ☐ No
29. STD's? ☐ Yes ☐ No
30. Chemo or Radiation Therapy? ☐ Yes ☐ No
31. Joint Replacement? ☐ Yes ☐ No
32. Fever Blisters or Shingles? ☐ Yes ☐ No
33. Colitis? ☐ Yes ☐ No
34. Facial Surgery? ☐ Yes ☐ No
35. Difficulty Breathing? ☐ Yes ☐ No
36. Sickle Cell Disease? ☐ Yes ☐ No
37. Seizures? ☐ Yes ☐ No

Are you now taking:

1. Drugs for high blood pressure? ☐ Yes ☐ No
2. Drugs for sleep? ☐ Yes ☐ No
3. Cortisone, steroids or ACTH? ☐ Yes ☐ No
4. Anticoagulants or blood thinner? ☐ Yes ☐ No
5. Tranquilizers or sedatives? ☐ Yes ☐ No
6. Antibiotics? ☐ Yes ☐ No
7. Insulin? ☐ Yes ☐ No
8. Have you ever taken Fen-Phen? ☐ Yes ☐ No
9. Others? ☐ Yes ☐ No
10. List any questions: _____

11. Have you been under the care of a physician for any major illness or injury other than those noted above? If so, list.

I Understand That Payment Is Due At Time Of Service.

I will pay today by: ☐ CASH ☐ CHECK ☐ CREDIT CARD

Patient / Guardian Signature

Relation to Patient: _____ Date: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA.

CRYSTAL FALLS DENTAL

FAMILY AND COSMETIC DENTISTRY

Date: _____

Dental History

Patient Name: _____ Birthdate: _____
First Last

How did you hear about us? _____

If referred, who may we thank for your referral? _____

What is the reason for today's visit? _____

What would you like to change about your smile? _____

Why did you leave your last dentist? _____

When was your last dental visit? _____

What did you like *most* about your last dentist? _____

Do your gums bleed while brushing or flossing? _____

Do you grind your teeth? _____

Do you snore or does your significant other snore? _____

Have you ever had prolonged bleeding after an extraction or surgery? _____

Are you currently having dental problems? _____

Preferred method for Contact? ..... ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email

Preferred contact method for Appointment Confirmations? ... ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email

Preferred contact method for Recall Appointments? ..... ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email

What are your dental concerns? *Check as many as are applicable:*

- ☐ Pain avoidance
- ☐ Appearance
- ☐ Losing teeth
- ☐ Gums/Periodontal Disease
- ☐ Cavities
- ☐ Oral Cancer
- ☐ Wasting/Exceeding Dental Insurance Limits
- ☐ Your general health
- ☐ Routine check up
- ☐ Cleaning

Other: _____

Please check the boxes if you are interested in any of the following:

- ☐ Invisalign – Clear Braces
- ☐ Implants
- ☐ Bad Breath Treatment
- ☐ Closing Gaps in Teeth
- ☐ 6 Month Braces
- ☐ More Attractive Smile
- ☐ Veneers / Lumineers
- ☐ Fixing Chipped Teeth
- ☐ Replacing Missing Teeth
- ☐ Preventing Cavities

Which TV Channel(s) do you prefer?

- ☐ HGTV ☐ ESPN ☐ Cartoon Network ☐ Travel Channel ☐ TLC ☐ E! TV
- ☐ Lifetime ☐ VH-1 ☐ Food Network ☐ Bravo ☐ Discovery Channel
- ☐ History Channel ☐ Other _____

Treatment Authorization

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary as advisable; including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. I also understand that payment for all treatment and services rendered is my responsibility.

Patient / Guardian Signature

Relation to Patient: _____ Date: _____

CRYSTAL FALLS DENTAL

FAMILY AND COSMETIC DENTISTRY

Date: _____

Patient Information

Patient Name: _____ Birthdate: _____ Age: _____
First MI Last

SS# _____ DL# _____ Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouses Name: _____ Work # _____

Home Address: _____ City: _____ St: _____ Zip: _____

Home # _____ Cell # _____ Work # _____ Fax # _____

E- Mail Address: _____ Occupation: _____

Employer Name and Address: _____

Emergency Contact: _____ Phone # _____ Relation: _____

Nearest Relative Not Living With You: _____ Relationship: _____ Phone # _____

Person Responsible for Account: _____ Relationship: _____

SS# _____ DL# _____ Home # _____

Home Address (if different): _____

Employer & Address: _____

Occupation: _____ Work # _____

Insurance Information

Primary Dental Carrier:

Subscriber: _____ Subscriber ID# _____ DOB: _____

Employer: _____ Insurance Company: _____

Insurance Company Phone # _____ Group # _____

Subscriber's Relation to Patient: ☐ Self ☐ Spouse ☐ Child Other: _____

Insurance Authorization

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Patient / Guardian Signature

Relation to Patient: _____ Date: _____