

PATIENT INFORMATION

Name: _____ Birth Date: _____ Social Security #: _____
Address: _____
Gender: Male Female Marital Status: Single Married Minor Email: _____
Home Phone #: (_____) _____ Cell #: (_____) _____ Other Phone #: (_____) _____
Occupation: _____ Employer: _____ Work Phone #: (_____) _____
Work Address: _____
Are you a student? Yes No Full time Part time School Name: _____
Spouse Name: _____ Occupation: _____ Phone #: (_____) _____
Person to contact in case of emergency: _____ Phone #: (_____) _____
Whom may we thank for referring you? _____

INSURANCE INFORMATION

Name of insured: _____ Relation to patient: _____
Birthday: _____ Social Security #: _____ Currently a patient in our practice? Yes No
Employer: _____ Work Phone #: (_____) _____
Insurance Company: _____ Group #: _____ Union or Local #: _____
Insurance Co. Address: _____ Phone #: (_____) _____
Annual deductible amount? _____ Maximum annual benefit? _____ Insurance benefits used this year? _____

SECONDARY INSURANCE INFORMATION

Name of insured: _____ Relation to patient: _____
Employer: _____ Birthday: _____ Social Security #: _____
Insurance Company: _____ Group #: _____ Union or Local #: _____

RESPONSIBLE PARTY

(Must complete if patient is under 18 or full time student)

Name of person responsible for this account: _____ Relation to patient: _____
Address: _____ Phone #: (_____) _____
Birthdate: _____ Currently a patient in our practice? Yes No Email: _____
Employer: _____ Work Phone #: (_____) _____

NATURE OF YOUR VISIT

Please indicate briefly the nature of your visit: _____

Please indicate if you are interested in receiving more information and discovering your options for any of the following

- services:
- Whitening: At Home or In Office
 - Getting Straighter Teeth: Invisalign or Conventional Braces
 - Cosmetic Dentistry: Porcelain Veneers
 - Replacement of Missing Teeth: Implants or Bridges
 - Full Mouth Reconstruction: Repair of the Severely Worn Down Dentition
 - Getting New Dentures: Conventional or Flexible
 - Treatment for Achy or Popping Jaw Joint or Night-time Grinding of Teeth
 - Treatment for Snoring

The highest complement our patients can give us,
is the referral of their friends and family.
Thank you for your trust.

HEALTH QUESTIONS

Do you have or have you ever had any of these conditions?

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Trouble? Type: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma? Date last episode? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Infective Endocarditis? | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy? Date last episode? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthetic Heart Valves? | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis? <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital Heart Disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No HIV or AIDS? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joints? Date: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Previously Infected Artificial Joint? | <input type="checkbox"/> Yes <input type="checkbox"/> No Systemic Lupus Erythematosus? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer? <input type="checkbox"/> Previously <input type="checkbox"/> Present | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Therapy? <input type="checkbox"/> Past <input type="checkbox"/> Current |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Inflammatory Arthritis? | <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy? <input type="checkbox"/> Past <input type="checkbox"/> Current |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Immunosuppression? | <input type="checkbox"/> Yes <input type="checkbox"/> No Taking Corticosteroids? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes? <input type="checkbox"/> Type1 <input type="checkbox"/> Type2
<input type="checkbox"/> Controlled? <input type="checkbox"/> Uncontrolled? | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Malnourishment? | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke? <input type="checkbox"/> Multiple? Date: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Care? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No To the best of your knowledge, do you know if you
need antibiotic premedication prior to dental visits? | <input type="checkbox"/> Yes <input type="checkbox"/> No Renal Failure? <input type="checkbox"/> Dialysis? |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No Uncontrolled Thyroid Disease? |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No Females: Are you pregnant? |

If answered Yes to any of the above questions, or there are more information about your health which should be known please explain as much as possible: _____

Yes No Are you taking any medication? Please list: _____

Yes No Are you allergic to: Latex Penicillin Cephalosporins Codeine Aspirin Non-Precious Metals Acrylic
Other: _____

Yes No Are you currently under a physician's care? Physician Name, Address and Telephone (if known):? _____

ACKNOWLEDGEMENT

1. Parents/Legal Guardians: I hereby certify that I am the legal guardian for the child whose information is entered in this form. I hereby authorize Crescent Dental, with my consent, to perform any and all necessary treatment in connection with the dental care of the patient above. Initial: _____

2. Insurance Bearers: You don't have to sign an insurance form at each dental visit. Crescent Dental will maintain this "Signature on File" for you.
AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to Crescent Dental for services rendered. Initial: _____
AUTHORIZATION TO RELEASE INFORMATION: I further authorize any provider, insurer or organization to release any information regarding the dental history, treatment or benefits payable to the plan administrator or its authorized agent for the purpose of determining ben Initial: _____

3. Financial Responsibility: I understand that as a courtesy to me Crescent Dental will assist me in filing my insurance claims. However, I am completely responsible for all fees in their entirety. I am fully aware that my insurer may not pay in full (or at all) for all services provided by Crescent Dental. An estimate of expenses not covered by my insurance is due at the time of service. I have received Crescent Dental Notice of Fina Initial: _____

4. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can jeopardize my (or Patient's) Health. It is my responsibility to inform Crescent Dental of any changes in medical status. Initial: _____

5. I authorize the use of my radiographs and/or photographs for use in lectures, seminars or publications of Crescent Dental. Initial: _____

6. I have received Crescent Dental Notice of Privacy Practices. Initial: _____

Patient/Parent/Guardian Signature: _____

Date: _____