CrimsonCare
FAMILY DENTAL

Please fill in completely and clearly

Patient Information:

Patient Name________________________________ Preferred Name____________ Date of Birth_________
Address________________________________ City__________________ State_________ Zip _________
Mark Appropriate Boxes: Male □ Female□ Child □ Single □ Married □ Divorced □ Separated □ Widowed □
Home Phone____________________ Work Phone_________________ Cell Phone____________________
Which number is the best to contact you at: Home Work Cell (circle one)
Social Security #______________________ Email ________________________________

Employment/School Information:

Present Employer________________________________ Position______________________________
Address ________________________________ City _________________ State_________ Zip__________
If college student: FT / PT School____ State____________

Family Information:

Spouse's name ____
Children's name(s)____________________________________ Date of Birth ______________________
_______________________________________ Date of Birth ______________________
_______________________________________ Date of Birth ______________________
_______________________________________ Date of Birth ______________________

Emergency Contact Information:

Name of person to contact in an emergency _________________________________ Phone _______________
Name of nearest relative not living with you ________________________________ Phone _______________

Insurance Information:

Person responsible for this account, if other than you __________________________ Relationship __________

Primary	Secondary (if applicable)
Insurance company__________________________	Insurance company__________________________
Name of policy holder _______________________	Name of policy holder _______________________
Employer of policy holder ____________________	Employer of policy holder ____________________
SS # of policy holder ________________________	SS # of policy holder ________________________
Birth date of policy holder ___________________	Birth date of policy holder ___________________
Policy number _____________________________	Policy number _____________________________
Group number _____________________________	Group number _____________________________
Circle one: Individual or Family coverage	Circle one: Individual or Family coverage

How did you hear about our office?

□ Relative □ Friend □ Coworker Name ____
□ Phonebook □ Website □ Driving by/Location

Payment is due at the time of service; if payment is not received within 30 days, a 1.5% monthly interest charge shall be accrued. I understand that I am financially responsible for all charges. In the event of a default on payment, the responsible party will pay collection costs and reasonable attorney fees and any other future outstanding amounts, which may increase my balance by up to 50%. I herby authorize the administration of medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

____ Date ______________________________
Signature (Parent or Guardian if minor)

Medical History

Please fill in completely and clearly

Birthdate ______________________________ Sex Male □ Female □

Are you under the care of a physician? Yes □ No □

If yes, for what reason? ____

Name of physician ____ Date of last exam __________________

List all medications you are currently taking and their doses ____

____

____

Have you had any surgeries? ____

Have you been advised by a physician of the need for any type of surgery or treatment? Yes □ No □

If yes, for what reason? ____

(Women) Are you pregnant? Yes □ No □ If yes, how long? ____

Do you suspect you may be pregnant? Yes □ No □

Are you allergic to: Penicillin □ Codeine □ Sulfa □ Latex □ Other □ __________________

____

Do you have, or have had any of the following:

Condition	Yes	No	Condition	Yes	No
Heart disease	Yes □	No □	Anemia	Yes □	No □
Circulatory problems	Yes □	No □	Arthritis	Yes □	No □
Heart murmur	Yes □	No □	Asthma or hay fever	Yes □	No □
Rheumatic fever	Yes □	No □	Back problems	Yes □	No □
Congenital heart defects	Yes □	No □	Chemical dependency	Yes □	No □
Abnormal blood pressure	Yes □	No □	Fainting spells	Yes □	No □
Diabetes	Yes □	No □	Glaucoma	Yes □	No □
Excessive urination or thirst	Yes □	No □	Headaches	Yes □	No □
Epilepsy	Yes □	No □	Jaundice	Yes □	No □
HIV positive or AIDS	Yes □	No □	Nervousness	Yes □	No □
Excessive bleeding	Yes □	No □	Psychiatric care	Yes □	No □
Stroke	Yes □	No □	Cancer	Yes □	No □
Artificial joint(s)	Yes □	No □	Radiation therapy	Yes □	No □
Pacemaker/defibrillator	Yes □	No □	Sinus trouble	Yes □	No □
Tuberculosis of lung disease	Yes □	No □	Thyroid problem	Yes □	No □
Hepatitis	Yes □	No □	Tonsillitis	Yes □	No □
Strep throat	Yes □	No □	Tumors	Yes □	No □
Venereal disease	Yes □	No □	Ulcers	Yes □	No □
Herpes simplex (cold sores)	Yes □	No □	Bisphosphate Therapy	Yes □	No □

Have you been advised to be premedicated prior to dental treatment for any of the above conditions?

Yes □ No □ Reason ____

Have you had any other serious illness, hospitalization or accident? Yes □ No □

If yes, explain ____

Is there anything else I should know about your medical history? ____

____

Patient signature ____ Date ________________________

(Parent or Guardian, if minor)

Recorded by ____________________________________ Dentist's Signature ______________________________