PATIENT INFORMATION

Name _____ Age _____ Date of birth _____ Weight _____ Sex: M F

Address _____ Driver's License # _____

City _____ State _____ Zip _____

Home Phone _____ Employer _____ Occupation _____

Work Phone _____ Email (#1) _____ SS# _____

Cell Phone _____ Would you like text reminders? Y N Do you have dental insurance? Y N

Person Responsible for Account: □ Patient □ Guardian □ Spouse □ Father □ Mother (if a minor)

Dental Insurance #1

Name of Insured: _____Insured's Date of Birth: _____ Relationship to Patient: _____ Sex M F

Insured's Address: _____ Insured's Phone #: _____

SS# of Insured: _____ Name & Address of Insur. Co. _____

Insurance Phone #: _____ Insurance Group #: _____Name of Employer: _____

Subscriber ID#: _____

Dental Insurance #2

Name of Insured: _____Insured's Date of Birth: _____ Relationship to Patient: _____ Sex M F

Insured's Address: _____ Insured's Phone #: _____

SS# of Insured: _____ Name & Address of Insur. Co. _____

Insurance Phone #: _____ Insurance Group #: _____Name of Employer: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____

Relationship _____

Cell Phone _____

Home # _____

Work # _____

Address _____

City/State/Zip _____

METHOD OF PAYMENT:

The estimated patient portion is due at each visit without exception.

The payment choices are as follows: (choose one)

□ Payment in full at each appointment by cash or check

□ Payment in full at each appointment by Visa, MC or Discover cards

□ Upon good credit and/or account history and with signed agreement:
2 to 3 post-dated checks paid at time of visit

□ CareCredit Payment Plan (on credit approval)

AUTHORIZATION: Please initial each statement below:

_____ I hereby authorize payment directly to the Dental Office of Insurance benefits otherwise payable to me.

_____ I understand that I am responsible for all costs of dental treatment, regardless of dental insurance and that if I default in paying my account, additional fees may be charged for collection of my debt.

_____ I realize that to get an exact estimate of treatment co –payments, I must contact my insurance company directly.

_____ 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 dental/medical histories are correct to the best of my knowledge.

_____ I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and / or other health professionals.

_____ I understand the office requires 2 working-days-notice for appointment changes or cancellations; otherwise I promise to pay fees of $50 per hour based on length of reserved appointment time; i.e., 1 hour = $50, 1.5 hours = $75.

_____ I understand that each dental practice is required to post certain notices, which are available online at www.cromeyerdental.com, if I wish to read them.

Subscriber ID#: _____

I understand and agree to the above, signed by patient or legal guardian:

_____ Date: _____

HEALTH HISTORY

Patient Name:_____ Today's Date: _____ Medical ID#: _____

Medical Doctor Name: _____ Phone: _____ Under a Dr.'s care now? Yes No

Date of last physical exam: _____ Name of Medical Insurance: _____Pharmacy Phone #: _____

Have you ever been told you need to pre-medicate with antibiotics before dental visits? Yes No Pharmacy Name: _____

Please mark yes or no for each question below. Do you have, or have you ever had the following:

	YES	NO		YES	NO		YES	NO		YES	NO
ADD/ADHD			Cough, Persistent or Bloody			High Blood Pressure			Sinus Trouble		
AIDS?HIV			Dental Phobia			Jaundice			Stroke		
Anemia			Diabetes			Jaw Clicking/Popping			Swollen Feet or Ankles		
Arthritis, Rheumatism			Dry Mouth			Jaw Pain/Tiredness			Swollen Neck Glands		
Artificial Heart Valves			Drug Usage:			Kidney Disease			Thyroid Problems		
Artificial Joints/Transplants			Methamphetamine			Liver Disease			TMJ Problems/History		
Autism			Marijuana			Low Blood Pressure			Tobacco Use		
Asthma			Other:Describe _____			Mitral Valve Prolapse			Sores of Mouth		
Back Problems			_____			Multiple Sclerosis			Tonsillitis		
Bleeding Abnormally,			Emphysema			Nervous Problems			Tuberculosis		
w/ extractions or surgery			Epilepsy			Osteoporosis			Tumors/Growths		
Blood Disease or Transfusion			Fainting or dizziness			Taking Osteoporosis Medication			on head or neck		
Bone Disease			Foreign Object in Mouth			Pacemaker			Ulcer		
Burning Sensation on Mouth/ Tongue			Glaucoma			Phobia			Venereal Disease		
Cancer: type _____			Headaches			Psychiatric Care			Weight Loss, Unexplained		
Chemical Dependency			Heart Murmur			Radiation Treatment			Wear Contact Lenses		
Chemotherapy			Heart Problems			Respiratory Disease			Women: Are you Pregnant?		
Circulatory Problems			Hepatitis Type: _____			Rheumatic Fever			Are you nursing?		
Congenital Heart Lesions			Herpes			Scarlet Fever			On Birth Control Pills?		
Cortisone Treatments			Flossing Trouble			Shortness of Breath			Taking Blood Thinners?		

Indicate ALLERGIES to: **PENNICILLIN** ◯ **LATEX** ◯ **ASPIRIN** ◯ **LOCAL ANESTHETIC** ◯

CODEINE ◯ **OTHER ANTIBIOTICS** ◯ **IODINE** ◯ **OTHER** ◯ _____

List all Medications (prescription and non-prescription): _____

_____

_____

List all surgeries AND conditions you think I should know about: _____

_____

_____

_____ _____ _____

Signed Patient or Guardian Relationship to patient Date

Updated: _____ (Initial & Date)

Per California Law, a new medical history is required once per year. Updates may be done during that one year period.

SMILE QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Reason for Today's visit: _____

How often do you brush your teeth? _____/day Floss your teeth? _____/day Use a tongue scraper: _____/day

Are you currently in pain with your teeth or gums? □ Yes □ No If yes, please describe: _____

_____

Have you recently been involved in a motor vehicle accident, or an accident involving your teeth? □ Yes □ No
If yes, please explain: _____

_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
Bad Breath			Food collection between the teeth			Orthodontic treatment		
Bleeding gums			Foreign objects			Pain around ear		
Blisters on lips or mouth			Gums swollen or tender			Periodontal treatment		
Chew on one side			Lip or cheek biting			Phobia of dentistry		
Cigarette, pipe, cigar use			Loose teeth			Sensitivity to heat		
Clicking or popping jaw			Broken fillings			Sensitivity to sweets		
Dry mouth			Mouth breathing			Sensitivity to biting		
Fingernail biting			Mouth pain, brushing			Sensitivity to cold		
Flossing Issues			Mouth pain, flossing			Sores or growths / mouth		

If you could wave a magic wand and change anything about the appearance of your smile, what would you like to do?
_____

Are you interested in changing your silver fillings to white fillings? □ Yes □ No

If you could easily and safely whiten your teeth, would you be interested in whitening? □ Yes □ No

Do you snore? □ Yes □ No Do you want more info about snore guard therapy? □ Yes □ No

Do you grind your teeth? □ Yes □ No Do you want more info on clenching/grinding guards? □ Yes □ No

Have you ever been treated for TMJ symptoms? □ Yes □ No If yes, please explain:_____

Please RANK the following in the order of which they would KEEP YOU from having dental treatment: (1 thru 4, 1 being most important)

_____FEAR of pain _____COST of treatment _____LACK of concern _____MISSING work time

If this is your first visit with us, how did you hear about our office? _____

Many people see us for a second opinion. Is this a second opinion? □ Yes □ No If so, please describe the nature of the problem:
_____

Previous Dentist Name: _____ **Phone:** _____ **Date of Last Visit:** _____ **Last X-rays:** _____

Reason for changing dentists: _____

Signed: ____ Date: ______________________________