PATIENT INFORMATION

Today's Date:_____ SS# _____ Driver Lic#_____

Name: (First)_____(Middle)_____(Last)_____
(Mr., Mrs., Ms., Miss, Dr.)

Local Address: _____City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ E-mail Address: _____

Date of Birth: _____/_____/_____ Age: _____ Female_____ Male_____

Employer:_____

Spouse or Parent's Name:_____Relationship:_____

Emergency Contact's Name:_____ Emergency Contact's Number:_____

Whom may we thank for referring you?_____

Pharmacy Name: _____ Pharmacy Phone Number:_____

RESPONSIBLE PARTY:

Name of person responsible for this account:_____

PATIENT DENTAL HISTORY:

Name of previous dentist: _____Location: _____Date of Last Exam_____

*Do You Take **PRE-MEDICATION** before dental treatment? Yes No (List Here):_____

Reason for PRE-MEDICATION _____

What is your present dental problem:_____

- Do you gums bleed while brushing/flossing? Yes No
- Are your teeth sensitive to hot/cold/sweets? Yes No
- Do you feel pain in any of your teeth? Yes No
- Do you have frequent headaches? Yes No
- Do you clench or grind your teeth? Yes No
- Have you had any orthodontic treatment? Yes No
- Do you like your smile? Yes No
- Would you like to have whiter teeth? Yes No
- Do you wear dentures or partials? Yes No

What would you like to change about your smile?

_____

_____

_____

PATIENT MEDICAL HISTORY:

Physician _____ Office Phone _____ Date of last exam_____

- Are you under medical treatment now? Yes No
- Do you use tobacco? Yes No
- Do you take aspirin daily? Yes No
- Have you ever been hospitalized for any surgical operation or serious illness? Yes No

Explain_____

Please list any medication(s) you are using:_____

Are you taking, or have ever taken, any medication for Osteoporosis? Please list:_____

OVER ⟶

Are you allergic to or have you had any reaction to the following: PLEASE CIRCLE

○ Local Anesthetics (eg. Novocain)	Yes	No	Women Only:		
○ Penicillin or other Antibiotics	Yes	No	Are you pregnant or think you are?	Yes	No
○ Sulfa Drugs	Yes	No	Are you nursing?	Yes	No
○ Barbiturates, Sedatives	Yes	No	Are you taking oral contraceptives?	Yes	No
○ Iodine	Yes	No	Are you on Hormone Replacement?	Yes	No
○ Aspirin	Yes	No			
○ Codeine or other narcotics	Yes	No			
○ Latex Rubber	Yes	No			
○ Other	Yes	No			

- If yes on other, please explain_____

- Do you have or have you had any of the following? PLEASE CIRCLE

Heart Murmur	Yes	No	Joint Replacement or Implant	Yes	No	When?_____
Mitral Valve Prolapse	Yes	No	Heart Disease	Yes	No	
Respiratory Problems	Yes	No	Heart Attack	Yes	No	
Cardiac Pacemaker	Yes	No	Tuberculosis	Yes	No	
Chronic Cough/Hoarseness	Yes	No	Rheumatic Fever	Yes	No	
Scarlet Fever/Pneumonia	Yes	No	Fainting/Seizures	Yes	No	
Nervous Disorder	Yes	No	Stroke	Yes	No	
High/Low Blood Pressure	Yes	No	Easily Winded/Shortness of Breath	Yes	No	
Anemia	Yes	No	Emphysema	Yes	No	
Epilepsy/Convulsions	Yes	No	Glaucoma	Yes	No	
Thyroid Problem	Yes	No	Arthritis	Yes	No	
Diabetes/Insulin	Yes	No	Burning Mouth	Yes	No	
Cancer	Yes	No	Leukemia	Yes	No	
Radiation Therapy	Yes	No	Recent Weight Loss	Yes	No	
Kidney Diseases	Yes	No	Liver Disease	Yes	No	
AIDS or HIV Infection	Yes	No	Hepatitis/A/B/C/Jaundice	Yes	No	
Stomach Troubles/Ulcers	Yes	No	Sexually Transmitted Disease	Yes	No	

-Do you have excessive bleeding following a scratch, cut, or tooth extraction: Yes No
-Do you have Osteoporosis? Yes No
-Do you currently take a blood thinner: Yes No

- Do you have any disease, condition, or problem not listed above that you think I should know about? If so, explain:

_____

Patient Financial Information:
Payment is expected at the time of service. Our financial coordinator will be happy to assist you with your financial options prior to your treatment. By signing this form, you agree to be fully responsible for total payment of procedures performed in this office. If you default, and Cromer & Cairns Dental has to refer this contract for collection to an attorney, you agree to pay reasonable attorney's fees and actual court costs.

Authorization for Insurance:
I authorize and request my insurance company to pay directly to the dentists listed. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of yourself or my dependents. I am fully aware that my insurance may not cover any treatment and I will be responsible to pay for all treatment performed. I also understand that my insurance company may still send payment directly to me and if this occurs, I will immediately forward this payment to the dental office to be applied towards my and/or dependent's bill. Cromer & Cairns Dental can only give estimates of insurance coverage and estimates are not a guarantee of payment.

Notice of Privacy Practices (NOPP) & Health Insurance Portability & Accountability Act (HIPPA):
We are required by law to maintain the privacy of our patients. You may find a summary of the HIPPA Privacy Rule and our NOPP in the reception area. If you have any questions regarding the privacy practices, please ask to speak with our HIPAA Compliance Officer in person or by calling (772) 562-5051.

AUTHORIZATION & RELEASE: I certify that I have read and understand the above information and have answered accurately to the best of my knowledge. I have had the opportunity to read and consider the content of this consent form and the NOPP/HIPPA. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. ***This includes contacting your doctor to gain medical clearance before moving forward with any potential dental procedure in our office, if the doctor deems it necessary to do so.**

X_____ **Date**: _____
Signature of Patient (or Parent of Minor)