PATIENT INFORMATION

First Name:_____ Last:_____ M.I._____ Sex: ☐M ☐ F

Social Security #_____ Date of Birth: _____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

Home # _____ Cell #_____

GUARDIAN/ POLICY HOLDER

First Name:_____ Last:_____ M.I._____ Sex: ☐M ☐ F

Social Security #_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home # _____ Cell #_____

Primary Insurance Plan:_____ Phone:_____

ID#:_____ Group#_____

EMERGENGY INFORMATION

Incase of Emergency Notify: _____ Phone_____ Relationship:_____

Dental History

_____
Previous Dental Office Date of Last Dental Visit

_____
Reason for Leaving

_____
Reason for Today's Visit

Who referred you to our office? (Doctor/Friend/Phonebook)_____Phone:_____

Please check any of the following that are a concern for you

[ ] Appearance / Color of Teeth
[ ] Pain or Discomfort
[ ] Cold/Heat Sensitivity
[ ] Pressure Sensitivity
[ ] Sweet Sensitivity
[ ] Bleeding Gums
[ ] Bad Breath
[ ] Food Collects
[ ] Grind / Clench Teeth
[ ] Dry Mouth
[ ] Headaches
[ ] Other

Patient (or Parent/Guardian) Signature:_____Date:_____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____
Are you on a special diet? ○ Yes ○ No _____
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Rheumatism ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Shingles ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Leukemia ○ Yes ○ No	Stroke ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Liver Disease ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Lung Disease ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pace Maker ○ Yes ○ No	Radiation Treatments ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No	

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Crescent Dental. A copy of this signed, dated Acknowledgement shall be as effective as the original.

Please Print Your Name

Please Sign Your Name

Date

Thank you and if you have any questions about this form or the attached Notice, please contact Rushdah Badeges.

For Office Use Only

As Privacy Official, I attempted to obtain the patient's (or representatives) signature on this Acknowledgment but did not because:

It was emergency treatment	____
I could not communicate with the patient	____
The patient refused to sign	____
The patient was unable to sign	
Because (please describe)	____

Signature Of Privacy Official

PATIENT FINANCIAL AGREEMENT

1. I understand that full payment is due at the time of service for myself and any party for whom I am financially responsible.

2. I understand that it is solely my responsibility to confirm which treatments or procedures are covered and/or paid by my insurance (including, but not limited to, any applicable exclusions, deductibles, annual or life time maximums)

3. I understand that as a courtesy Crescent Dental will attempt to verify my insurance coverage from information that I provide and will file two claims per appointment. I am required to pay in full, before treatment is performed, the estimated portion of any procedures of treatment that will not be covered by my insurance.

4. I understand that insurance claims will only be filed if I provide Crescent Dental with my social security and insurance identification numbers. If I choose not to provide Crescent Dental with my SSN, I understand that I must pay in full for all services rendered. It is Crescent Dental's policy to require SSN numbers and a copy of government-issued picture identification (driver's license) for recordkeeping purposes.

5. I understand that although I pay my estimated patient balance on the date of service, the insurance estimate may differ from what my insurance carrier actually pays. If this happens I will receive a statement for the balance due which will be payable upon receipt.

6. I understand that account balances over 90 days may be turned over to a collections agency and any additional fees associated with the collection process will be my responsibility. *However, we do not enjoy sending patients to collections and will try to make financial arrangements on overdue accounts.*

7. I understand I will be charged $35 for any returned check.

8. I understand that if I discontinue treatment for a requested procedure, including but not limited to, partials, dentures, crowns, bridgework, and surgical preparatory work, I remain responsible for paying all lab related costs for materials and services that were incurred before I discontinued treatment. All related costs will be deducted from any refund to which I may be entitled for discontinued treatment and I may receive a bill/ statement for a balance due.

9. I authorize release of any information relating to claims and I also authorize payment directly to AmeerZ Dental.

I have thoroughly read, understand and agree to the above terms can conditions.

_____ _____

Printed Name Date

_____ _____

Signature of Patient (or authorized guardian) If authorized guardian, relationship to patient