Patient Information

Patient Name: ____ Date: ____________________

Gender (M/F): ________ Marital Status: ______________ Date of Birth: _____________________

Social Security #: _________________________ E Mail Address: _________________________

Address: ____

City/State: _____________________________ Zip Code: ______________________________

Home Phone: ____________________________ Work Phone: ___________________________

Cell Phone: _____________________________ Other: ________________________________

Referral Source

Name of Person, Office or Other source referring you to our practice: ___________________________

Spouse or Responsible Party

Name: _______________________________________ Relationship: _____________________

Date of Birth: _____________________ Social Security #: ______________________________

Home Phone: _____________________ Work Phone: __________________________________

Cell Phone: ______________________ Other: _______________________________________

Employment Information

Employer: ____

Address: ____

Insurance Information

Name of Insured: ____

Insured's Date of Birth: ________ Social Security #: __________________ ID #: ______________

Insurance Company: ____

Insurance Address: ____

Insurance Phone Number: ____

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I revoke previous agreements to the contrary and agree to be responsible for payments and services not paid, in whole or in part by my dental care payor. I attest to the accuracy of the information on this page.

Patient or Guardian: ____

Date: ____

MEDICAL HISTORY

Date of Last Dental Visit: ____________________________

Physician's Name: ____________________________ Address ____________________________

Are you under a physician's care? Yes No

Since When? ____________________________

Why? ____________________________

When was your last complete physical exam? ____________________________

Are you taking any medications or substances? Yes No

If yes, please list medications ____________________________

Do you routinely take health related substances? Yes No

Are you allergic to any medications or substances? Yes No

If yes, please list ____________________________

Do you have any other allergies or hives? ____________________________

Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ______________

Are you sensitive to any metals or latex? Yes No

Are you pregnant or suspect you may be? Yes No

Do you use any birth control medications? Yes No

Have you ever been treated for or been told you might have heart disease? Yes No

*Do you have a pacemaker or an artificial heart valve implant? Yes No

*Have you previously had infective endocarditis (IE)? Yes No

*Have you ever been told that you were born with congenital heart disease? Yes No

Have you ever had rheumatic fever? Yes No

Are you aware of any heart murmurs? Yes No

Have you ever had radiation treatment, chemo treatment for tumor, growth or other conditions?
Yes No

Do you have inflammatory disease, such as arthritis or rheumatism? Yes No

Do you have any artificial joints/prosthesis? Yes No

Do you have any blood disorders, such as anemia, leukemia, etc? Yes No

Have you ever bled excessively after being cut or injured? Yes No

Do you have any stomach problems? Yes No

Do you have any kidney problems? Yes No

Do you have any liver problems? Yes No

Are you a diabetic? Yes No

Do you have High or Low Blood Pressure? Yes No

Do you have fainting or dizzy spells? Yes No

Do you have asthma? Yes No

Do you have epilepsy or seizure disorders? Yes No

Do you or have you ever had venereal disease? Yes No

Have you tested HIV positive? Yes No

Do you have AIDS? Yes No

Have you had or do you test positive for hepatitis? Yes No

Do you or have you had T.B.? Yes No

Do you smoke, chew, use snuff or any other forms of tobacco? Yes No

Do you consume alcoholic beverages? Yes No

Have you had psychiatric treatment? Yes No

Have you taken any prescription drugs fenfluramine, fen-phen, redux, or other weight loss products?
Yes No

Do you have any disease condition, or problem not listed? Yes No

If so, please explain ____________________________

Is there anything else we should know about your health that we have not covered in this form?
Yes No

Would you like to speak to the Doctor privately about any problem? Yes No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN SIGNATURE ____________________________

Crescent Dental

Kavita Ghai, D.D.S., P.L.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

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* You May Refuse to Sign This Acknowledgement *

I, ____, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtain because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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