Bruce E. Crowley, DDS

Family & Cosmetic Dentistry

1 About You

Today's Date: _____

E-mail Address: _____

Name: _____

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: ___/___/____ Age: _____ SS#: _____

Home Address: _____

_____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm#:(____) _____ Cell#:(____) _____

Wk# :(____) _____ Ext:____ DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are the best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Last visit date: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Wk# :(____) _____ Ext:____ SS#: _____

Birthdate: ___/___/____ DL#: _____

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/____ Insured's ID#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/____ Insured's ID#: _____

Insured's Employer: _____

4 Medical History

Do you have a personal physician? ❑ **Yes** ❑ **No**

Physician's Name: _____

Phone #: (____)_____ **Last Visit Date:** _____

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation _____

Wk#:(____) _____ Hm#:(____) _____

Continued on back

5 Medical History Continued

Have you ever had any of the following diseases or medical problems?

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Abnormal Bleeding	❑	❑	Emphysema	❑	❑	HIV+ / AIDS	❑	❑	Rheumatic / Scarlet Fever
❑	❑	Alcohol/Drug Abuse	❑	❑	Epilepsy	❑	❑	Hospitalized for Any Reason	❑	❑	Seizures
❑	❑	Anemia	❑	❑	Fainting Spells	❑	❑	Kidney Problems	❑	❑	Shingles
❑	❑	Arthritis	❑	❑	Frequent Headaches	❑	❑	Liver Disease	❑	❑	Sickle Cell Disease
❑	❑	Artificial Bones/ Joints/ Valves	❑	❑	Glaucoma	❑	❑	Low Blood Pressure	❑	❑	Sinus Problem
❑	❑	Asthma	❑	❑	Hay Fever	❑	❑	Lupus	❑	❑	Stroke
❑	❑	Blood Transfusion	❑	❑	Heart Attack	❑	❑	Mitral Valve Prolapse	❑	❑	Thyroid Problems
❑	❑	Cancer / Chemotherapy	❑	❑	Heart Murmur	❑	❑	Osteoporosis / Osteopenia	❑	❑	Tuberculosis (TB)
❑	❑	Colitis	❑	❑	Heart Surgery	❑	❑	Pacemaker	❑	❑	Ulcers
❑	❑	Congenital Heart Defect	❑	❑	Hemophilia	❑	❑	Psychiatric Problems	❑	❑	Venereal Disease
❑	❑	Diabetes	❑	❑	Hepatitis	❑	❑	Radiation Treatment	❑	❑	Do you smoke?
❑	❑	Difficulty Breathing	❑	❑	Herpes / Cold Sores				❑	❑	Do you use chewing tobacco?
			❑	❑	High Blood Pressure						

Please list any other medical condition(s) you may have:

_____

6 Dental History

Has your doctor told you that you require antibiotics before treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Have you ever had periodontal treatment? ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles: ❑ Hard ❑ Medium ❑ Soft

1-4 Below for women only: (Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected Delivery date:_____

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills? ❑ Yes ❑ No

7 Medications

Are you taking a blood thinner? ❑ Yes ❑ No

Are you taking any prescription / over-the-counter or herbal supplement drugs? ❑ Yes ❑ No

Please list each one: _____

_____

_____

8 Allergies

Are you allergic to any of the following?

Yes	No		Yes	No	
❑	❑	Aspirin	❑	❑	Latex
❑	❑	Codeine	❑	❑	Penicillin
❑	❑	Dental Anesthetics	❑	❑	Tetracycline
❑	❑	Erythromycin	❑	❑	Other
❑	❑	Jewelry / Metals			

Please list any other drugs / materials that you are allergic to:

_____

_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Reviewed by**

X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/ or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I herby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**