BRUCE E. CROWLEY, DDS

FAMILY & COSMETIC DENTISTRY

Today's Date:
E-mail Address:
Name:
I prefer to be called:
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:

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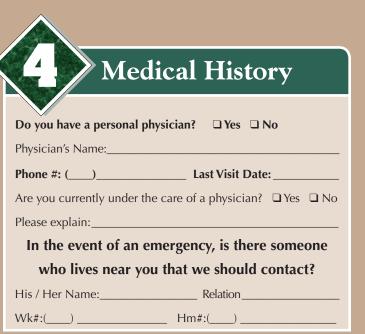
Dental Insurance

Primary Dental Insurance

Insurance Co. Name:			
Insurance Co. Address: _			
)		
Group # (Plan, Local or Policy #):			
Insured's Name:	Relation:		
	/ 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:// Ins	ured's ID#:
Insured's Employer:	



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Medical History Continued	ical maklama?
Have you ever had any of the following diseases or med Yes No Abnormal Bleeding Emphysema Alcohol/Drug Abuse Epilepsy Anemia Fainting Spells Arthritis Frequent Headaches Artificial Bones/ Joints/ Glaucoma Valves Hay Fever Asthma Heart Attack Blood Transfusion Heart Murmur Cancer / Chemotherapy Heart Surgery Colitis Hemophilia Diabetes Herpes / Cold Sores Difficulty Breathing High Blood Pressure	Yes No Yes No Image: High High High High High High High High
<u> </u>	<u>^</u>
Dental History Has your doctor told you that you require antibiotics before treatment? Are you currently in pain? Have you ever had a serious / difficult problem associated with any previous dental work? Do you or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?	Are you taking a blood thinner? Yes Are you taking any prescription / over-the-counter or herbal supplement drugs? Yes Please list each one:
Your current dental health is:GoodFairPoorHave you ever had periodontal treatment?YesNoDo you like your smile?YesNoDo your gums ever bleed?YesNoHow many times a week do you floss?YesNoHow many times a day do you brush?YesSoftType of bristles:HardMediumSoft	B Allergies Are you allergic to any of the following? Yes No Yes No Aspirin Latex Codeine Penicillin
 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? 2) Expected Delivery date:	 Dental Anesthetics Tetracycline Erythromycin Jewelry / Metals Please list any other drugs / materials that you are allergic to:
3) Are you nursing? □ Yes □ No 4) Are you taking birth control pills? □ Yes □ No	
tity that I have read and I understand the guartiene above I advice what a th	at my questions, if any, about the inquiries set forth above have been answered ble for any errors or omissions that I have made in the completion of this form.
faction. I will not hold my doctor, or any other member of his / her staff, responsi X	X

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X _____ Date

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allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deduct not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees, and court costs. X _____ Date X Signature of patient (Parent or Guardian if Minor) 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 ______ Date Signature of patient (Parent or Guardian if Minor)
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 X _____ Date I may have regarding this notice.

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