WELLCOME

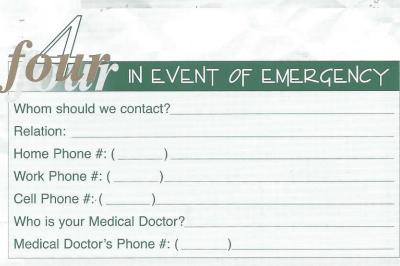
one

ABOUT YOU

Today's Date:	/	/	File #:
Patient Name:		FIRST	MI
2.0.			
What You Prefer To Be	Called:		
Birthdate://	Age:_	SS#	t:
Mailing Address:			
O.T.		07475	710
CITY	`	STATE	ZIP
Home Phone #: (,		
Work Phone #: ()		Ext:
Cèll Phone #: (_)		
E-mail Address:			
Referred By:			
Employer:		Но	w Long?
Employer's Address:			
CITY		STATE	ZIP
Occupation:		A CONTRACTOR STANCE OF THE STA	
Status: ☐ Minor ☐ Single	☐ Married ☐	Divorced 🗆 S	Separated Widowed
Spouse's Name:			
Do you have children?	□ Yes □ N	No How r	nany?



UXXIII)	INSURANCE	INF
Primary Dental Insuran	ce	
Co. Name:		
Address:		
CITY	STATE	ZI
Phone #: ()		
Insured's ID#:		
Group # (Plan, Local, or Po		
Insured's Name:		,
Relation:		
Insured's Employer:		
Secondary Dental Insul		
Co. Name:		
Address:		
CITY	STATE	ZI
Phone #: ()		
Insured's ID#:		
Group # (Plan, Local, or Po	olicy #):	
	, ,	
Relation:		/
Insured's Employer:		
inicaroa o Employer.		



PLEASE CONTINUE ON BACK

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DENTAL INFORMATION
Reason for today's visit: Exam Emergency Consultation
Are you in pain? No Yes How Long?
Please indicate any of the following problems:
□ Discomfort, clicking or popping in jaw. □ Lost/Broken Filling(s) □ Stained teeth
□ Red, swollen or bleeding gums. □ Teeth grinding □ Locking Jaw
☐ Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad breath
☐ Blisters/Sores in or around the mouth. ☐ Broken/Chipped tooth
□ Other:
Do you require pre-medication? ☐ Yes ☐ No ☐ Don't know
Previous Dentist: ()
Name Phone#
Last Dental exam: / / Last Dental X-rays: / /
Times a day you brush? Times a week you floss?
What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard
How would you rate your smile? $(Worst)$ 1 2 3 4 5 6 7 8 9 1 0 $(Best)$



		MEDICAL HI	STORY
		Ils	
Have you ever taken: Bis Do you have or have you! Y N Heart Attack / Stroke Y N Heart Surg./Pacemaker Y N Heart Murmur Y N Rheumatic Fever Y N Mitral Valve Prolapse Y N Artificial Valves Y N Heart Disease Y N Congenital Heart Defect Y N Chest Pains Y N Scarlet Fever	Y N Thyroid Problems Y N Kidney Problems Y N Liver Problems Y N Respiratory Problems Y N Sinus Problems Y N Stomach Problems/Ulcers Y N Psychiatric Problems Y N Venereal Disease Y N Alcohol/Drug Abuse	seases, medical conditions or procedures Y N Cancer/Tumors Y N Cosmetic Y N Shingles Y N Xray or Co Y N Hepatitis Y N Chemothe Y N HIV+/AIDS/ARC Y N Asthma Y N Arthritis/ Rheumatism Y N Difficulty E	Surgery Surgery Shalt Treatment Frapy Breathing Hypoglycemia Blood Pressure Problems
Please list any other surg	geries or medical conditio	ns you have or ever had:	
Are you allergic to any of	f the following? Latex	☐ Penicillin / Amoxicillin ☐ Tetracycline	e □ Aspirin
☐ Dental Anesthetics ☐	Foods:	Others:	
Do you use tobacco? 🗆	No ☐ Yes/How used?	How much? Hov	v long?
		Do you wear contact lenses? Yes □ No How many children have yo	The state of the s
Are you Pregnant? U No	o ☐ Yes/How long?	Are you nursing? Yes No	

	Are you Pregnant? ☐ No ☐ Yes/How long? Are you nursing? ☐ Yes ☐ No		
	ite you to discuss with us any questions regarding our services. The best Dental health services are based endly, mutual understanding between provider and patient.		DATE ICE USE)
made v	icy requires payment in full for all services rendered at the time of visit, unless other arrangements have been with the business manager. If account is not paid within 90 days of the date of service and no financial aments have been made, you will be responsible for legal fees, collection agency fees, interest charges and er expenses incurred in collecting your account.	Initials	/ / Date
♦ I autho	rize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the r to release any information required to process insurance claims.	Initials	/ / Date
	stand the above information and guarantee this form was completed correctly to the best of my knowledge derstand it is my responsibility to inform this office of any changes to the information I have provided. I acknowledge that I have received a copy of the Summary of Privacy Notice.	Com	nments / / Date
Initia	Signature Date / /	Con	nments



Relation:_

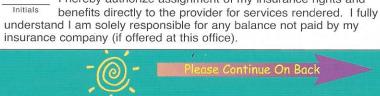
Insured's Employer: _





About Your Child	{	Child's Family Information
Today's Date:// File #:	The	Who is accompanying this child today?
Child's Name: LAST FIRST M.I.		FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD Do you have Legal Custody of this Child? Yes No
Child's Nickname: Boy _ Girl		How many Brothers/Sisters? Age(s):
Child's Birthdate:/ / Age:		Mother's Name
School: Grade:		Mother's Name: STEP MOTHER
Child's Home Phone #:()		(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP
Child's SS#:		*
Child's Address:		HOME PHONE # EXT.
HOME ADDRESS		/ / / MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #
CITY STATE ZIP		
Referred By:(If doctor, please give address & phone number.)		Employer: How Long?
(ii doctor, piease give address & priorie number.)		EMPLOYER'S ADDRESS CITY STATE ZIP
		Father's Name: STEP FATHER ☐ GUARDIAN
Insurance Information		(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP
Primary Dental Insurance		(
Co. Name:		
Address:		FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #
, tudi 500.		Employer: How Long?
CITY STATE ZIP		
Phone #:		EMPLOYER'S ADDRESS CITY STATE ZIP
Insured's ID#:		
Group # (Plan, Local, or Policy #):		
Insured's Name:		Account Information
Relation:Date of Birth://		Person ultimately responsible for account
Insured's Employer:		Name:
Does either policy cover Orthodontics? Yes No		RELATION TO CHILD
Secondary Dental Insurance		Billing Address:
Co. Name:		CITY STATE ZIP
Address:		
		SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #
CITY STATE ZIP		()
Phone #:		Payment method:
Insured's ID#:		
Group # (Plan, Local, or Policy #):		☐ Credit Card - Enter card # above (if accepted)
Insured's Name:		I hereby authorize assignment of my insurance rights and

_Date of Birth: ___ / ___ /



I hereby authorize assignment of my insurance rights and

		5		5.1
		05	Child's Denta	l Information
		Reason for today's visit:	☐ Emergency ☐ Consi	ultation
	((0))	Is Child in pain? No Yes How	0	
		Please indicate any of the following Discomfort, clicking or popping in		(a) Stained tooth
		Red, swollen or bleeding gums.		Locking Jaw
		☐ Sensitive tooth, teeth or gums.	Ringing in Ears	Bad breath
	,	☐ Blisters/Sores in or around the m	nouth. Broken/Chipped to	ooth 🔲 Loose tooth
	met .	Other(s): Does child require pre-medication?	☐ Yes ☐ No ☐ Don't kr	now
		Previous Dentist:		
		Last Dental exam://	Last Dental X-rays:	_//
to	1. To de de	Times a day child brushes?		es?
4		Is the child's water fluoridated?		7 0 0 10
	the officer of the second	How would you rate the child's smile	9. Best 1 2 3 4 5 6	7 8 9 10 Worst
	6			
			s Medical History	
177	Is Child taking any of the following me Blood Thinners Tranquilizers Ir			
丛	Child's Physician:	(
	DOCTOR'S NAME OR CLIN		cal Exam://	
	ADDRESS CITY Does Child have or ever had any of	STATE ZIP		
	Y N Heart Murmur Y N	Tonsillitis Y N	High/Low Blood Pressure Hepatitis	
	Y N Artificial Heart Valves Y N	Asthma/Difficulty Breathing YN	Artificial Bones/Joints/Implants	
	Y N Scarlet Fever Y N	Leukemia/Anemia YNI	Liver/Kidney/Organ Problems HIV+/AIDS/ARC	_ <
		31.03	Tuberculosis TB Psychiatric Problems	
		[1] 10 [1] 12 [14 [14 [14] 14 [14] 14 [14] 14 [14] 14 [14] 15 [14] 15 [14] 15 [14] 15 [14] 15 [14] 15 [14] 15	Hyper Active/ADD Fainting/Seizures/Epilepsy	
4	Y N Hearing Problems Y N	Birth Defects Y N (Cerebral Palsy	
	Please list any other medical condition	n(s) child has or ever had:		, ;]
AG .	Is Child allergic to: Latex Penicil	lin/Amoxicillin	ntal Anesthetics (Novocaine)	
	☐ Aspirin ☐ Food allergies ☐ Other			
1	Please rate the child's general health f	rom 1-10: Does child wear o	contact lenses? Yes No	
7	Has this child ever taken the drug Rita Does this child do any of the following			T
	☐ Heavy Snoring ☐ Mouth Breathing		Torigue Tirusting/Sucking	从
				7
	■ We invite you to discuss with us any qu	estions regarding our services. The best F	Dental health services are base	UPDATE (OFFICE USE)
	on a friendly, mutual understanding between	een provider and patient.		
		count is not paid within 90 days of the	date of service and no financia	I Milaio Balo
	arrangements have been made, you will any other expenses incurred in collecting	be responsible for legal fees, collection as your account.	gency tees, interest charges and	Comments
	I authorize the staff to perform any nece provider to release any information require	red to process insurance claims.		
	I understand the above information and and understand it is my responsibility to i	guarantee this form was completed correct of the info	ctly to the best of my knowledge ormation I have provided.	
	Signature	Date	e/	Initials Date Comments
	☐ Parent or	Guardian Groner:		Comments

Crown Point Dental Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

Ι, –		, have received a copy of this
office'	s N	otice of Privacy Practices.
Please	Prin	t Name
Signatu	ıre	
Date		
		For Office Use Only
		ed to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but gement could not be obtained because:
		Individual refused to sign
*		Communications barriers prohibited us from obtaining acknowledgement
		An emergency situation prevented us from obtaining acknowledgement
		Other (Please Specify)
		s *
	07	