WELCOME

one — ABOUT YOU

Today's Date: ____/____/____ File #: ______

Patient Name: ______
LAST FIRST MI

What You Prefer To Be Called: ______ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: ______ SS#: ______

Mailing Address: ______

______
CITY STATE ZIP

Home Phone #: (______) ______

Work Phone #: (______) ______ Ext: ______

Cell Phone #: (______) ______

E-mail Address: ______

Referred By: ______

Employer: ______ How Long? ______

Employer's Address: ______

______
CITY STATE ZIP

Occupation: ______

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ______

Do you have children? ❑ Yes ❑ No How many? ______

two — INSURANCE INFO

Primary Dental Insurance

Co. Name: ______

Address: ______

______
CITY STATE ZIP

Phone #: (______) ______

Insured's ID#: ______

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

Insured's Name: ______

Relation: ______ Date of Birth: ___/___/___

Insured's Employer: ______

Secondary Dental Insurance

Co. Name: ______

Address: ______

______
CITY STATE ZIP

Phone #: (______) ______

Insured's ID#: ______

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

Insured's Name: ______

Relation: ______ Date of Birth: ___/___/___

Insured's Employer: ______

three — ACCOUNT INFO

Person ultimately responsible for account

Name: ______

Relation: ______

Billing Address: ______

______
CITY STATE ZIP

SS #: ______

Drivers License #: ______

Work Phone #: (______) ______

Payment method: ❑ Cash ❑ Check

______ ___/___

❑ Credit Card - Enter card # above (if accepted)

______
Initials

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four — IN EVENT OF EMERGENCY

Whom should we contact? ______

Relation: ______

Home Phone #: (______) ______

Work Phone #: (______) ______

Cell Phone #: (______) ______

Who is your Medical Doctor? ______

Medical Doctor's Phone #: (______) ______

5 five

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 10 (Best)

6 six

MEDICAL HISTORY

What medications are you taking? ❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Meds for Osteoporosis
❑ Other(s), please list: ______________
Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No
Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/ Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: ______________
____
Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin
❑ Dental Anesthetics ❑ Foods: ______________ ❑ Others: ______________
Do you use tobacco? ❑ No ❑ Yes/How used? ________ How much? ________ How long? ________
Please rate your general health from 1-10: ________ Do you wear contact lenses? ❑ Yes ❑ No
For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? ________
Are you Pregnant? ❑ No ❑ Yes/How long? ________ Are you nursing? ❑ Yes ❑ No

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand 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.

________ Initials

Signature ______________ Date ____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

________ Initials ____/____ Date
Comments

________ Initials ____/____ Date
Comments

________ Initials ____/____ Date
Comments

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WELCOME

1 About Your Child

Today's Date: ____/____/____ File #: ________

Child's Name: ______________________
LAST FIRST M.I.

Child's Nickname: ______________ ❑ Boy ❑ Girl

Child's Birthdate: ____/____/____ Age: ________

School: ______________________ Grade: ______

Child's Home Phone #: (______) ______________

Child's SS#: ______________________

Child's Address: ______________________
HOME ADDRESS

____
CITY STATE ZIP

Referred By: ______________________
(If doctor, please give address & phone number.)

____

2 Insurance Information

Primary Dental Insurance

Co. Name: ______________________

Address: ______________________

____
CITY STATE ZIP

Phone #: ______________________

Insured's ID#: ______________________

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

Insured's Name: ______________________

Relation: ____________ Date of Birth: ___/___/___

Insured's Employer: ______________________

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: ______________________

Address: ______________________

____
CITY STATE ZIP

Phone #: ______________________

Insured's ID#: ______________________

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

Insured's Name: ______________________

Relation: ____________ Date of Birth: ___/___/___

Insured's Employer: ______________________

3 Child's Family Information

Who is accompanying this child today?

______________________ ______________________
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters? ______ Age(s): _____ _____ _____

Mother's Name: ______________________
❑ STEP MOTHER ❑ GUARDIAN

____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(______)____________ (______)____________ ______
HOME PHONE # WORK PHONE # EXT.

______________ ____/____/____ ______________
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: ______________________ How Long? ______

____
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: ______________________
❑ STEP FATHER ❑ GUARDIAN

____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(______)____________ (______)____________ ______
HOME PHONE # WORK PHONE # EXT.

______________ ____/____/____ ______________
FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: ______________________ How Long? ______

____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account

Name: ______________________ ______________
RELATION TO CHILD

Billing Address: ______________________

____
CITY STATE ZIP

______________ ____/____/____ ______________
SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(______)____________ ______ (______)____________
WORK PHONE #: EXT. CELL PHONE #:

Payment method: ❑ Cash ❑ Check

______________________ ____/____

❑ Credit Card - Enter card # above (if accepted)

______ I hereby authorize assignment of my insurance rights and
Initials benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please Continue On Back

5 Child's Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Child 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 ❑ Loose tooth
❑ Other(s):____________________

Does child require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist:____________________ (_____)____________

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day child brushes? _______ Times a week child flosses? ____________

Is the child's water fluoridated? ❑ Yes ❑ No

How would you rate the child's smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

6 Child's Medical History

Is Child taking any of the following medications? ❑ Pain killers (INCLUDING ASPIRIN) ❑ Ritalin ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle relaxers ❑ Others:____________

Child's Physician:____________________ (_____)____________
DOCTOR'S NAME OR CLINIC NAME PHONE#

____________________ Last Medical Exam: ____/____/____
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** High/Low Blood Pressure
Y N Rheumatic fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma/Difficulty Breathing	**Y N** Artificial Bones/Joints/Implants
Y N Congenital Heart defect	**Y N** Blood Transfusion(s)	**Y N** Liver/Kidney/Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV+/AIDS/ARC
Y N Surgeries/Operations	**Y N** Diabetes/Hypoglycemia	**Y N** Tuberculosis TB
Y N Cancer/Tumors	**Y N** Hemophilia	**Y N** Psychiatric Problems
Y N Chemotherapy	**Y N** Abnormal Bleeding	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting/Seizures/Epilepsy
Y N Hearing Problems	**Y N** Birth Defects	**Y N** Cerebral Palsy

Please list any other medical condition(s) child has or ever had:____________________

Is Child allergic to: ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics (Novocaine)
❑ Aspirin ❑ Food allergies ❑ Other(s):____________________

Please rate the child's general health from 1-10: _______ Does child wear contact lenses? ❑Yes ❑No

Has this child ever taken the drug Ritalin? ❑ No ❑ Yes/How long?_______ Child's Blood type:______

Does this child do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking
❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

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- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ____________________ Date ____/____/____
❑ Parent or Guardian ❑ Other:

UPDATE
(OFFICE USE)

Initials	Date
______	__/__/__
Comments	
______	__/__/__
Comments	
______	__/__/__
Comments	

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Crown Point Dental Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 obtained because:

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

____

____

____