CROSS DENTAL

Patient Information

Date: _____ SS/HIC/Patient ID: _____

Last Name: _____ First Name: _____

Address: _____

Email: _____

City: _____

State: _____ Zip Code: _____

Sex: ☐ Male ☐ Female

Age: _____ Birthday: _____

Relationship Status:

☐ Married ☐ Single ☐ Minor
☐ Widowed ☐ Separated ☐ Divorced
☐ Partnered for _____ years

Patient Employer/School: _____

Occupation: _____

Employer/School Address: _____

Employer/School Phone: _____

SPOUSE

Spouse's Name: _____

Birthday: _____ SS#: _____

Spouse's Employer: _____

Where did you hear about us? Name of referral?

☐ Website ☐ Google ☐ Other Online Source
☐ Article / Blog (list below) ☐ Family ☐ Friend
☐ Other Reference (please list below)

_____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

Is patient covered by additional insurance? _____

Subscriber's name: _____

Birthday: _____ SS#: _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with:

_____ and assign directly to

Dr. _____

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges weather or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
(Signature of Patient, Parent, Guardian, or Personal Representative)

_____
(Please print name of Patient, Parent, Guardian, or Personal Representative)

_____ _____
Date Relationship to Patient

Phone Numbers

Home: _____ Work: _____ Ext. ____ Alt. Phone: _____

Spouse's Work: _____ Best time and place to reach you? _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Phone _____ Alt. Phone _____

Dental History

Reason for today's visit: _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-Rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No

Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding Teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No

Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity twhen biting	☐ Yes	☐ No
Mouth sores/growths	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine) Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Check to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or Dizziness	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bleeding abnormally	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
(with extractions or surgery)	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tumor or Growth on Head or Neck	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Cough (persistent or bloody)	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			
Do you wear contact lenses?	☐ Yes	☐ No						

Women:

Are you pregnant? ☐ Yes ☐ No Due Date _____ Are You Nursing ☐ Yes ☐ No

Taking Birth Control Pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone _____

Allergies

☐ Asprin	☐ Local Anasthetic
☐ Barbiturates (sleeping pills)	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Iodine	☐ Other
☐ Latex	_____

Updates (To be filled in at future appointment use)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?

Are you taking any new medications? ☐ Yes ☐ No If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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