Smile
Advanced Dental Care

David T Crowe DDS, MAGD

Patient Information

Name: _____ Date: _____
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child Birth Date: _____ Social Security #: _____

Address: _____
Street Apartment # City State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____(E-mail)_____

Employer Name: _____ Occupation: _____

Address:

_____
Street City, State Zip Code Phone

Referral Information

Whom may we thank for referring you to our practice? : _____

OR

How did you hear about our office? _____

Responsible Party Information – (If different from Patient)

Name: _____
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single Birth Date: _____ Social Security #: _____

Address: _____
Street City, State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information

Primary

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ SS #: _____ Group #: _____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Insurance Plan Name: _____ Phone Number: _____

Secondary

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ SS #: _____ Group #: _____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Insurance Plan Name: _____ Phone Number: _____

For Office Use Only

Updated: _____ by:_____ Updated: _____ by:_____ Updated: _____ by _____
Updated: _____ by _____ Updated: _____ by _____ Updated: _____ by _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies_____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Codeine Allergy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Epinephrine Allergy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Neck Surgery
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Phen-fen
- ☐ Pregnancy Due date:_____
- ☐ Pre-Med
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Sinus Problems
- ☐ STD's
- ☐ Sulfa Allergy
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

OTHER:

- ☐ _____
- ☐ _____

- Have you ever had any complications or been dissatisfied with dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you currently taking any medications? ☐ Yes ☐ No If so, please list: _____
- Do you smoke or use tobacco? ☐ Yes ☐ No
- Are you aware of clenching or grinding of your teeth? ☐ Yes ☐ No
- Are you unhappy with the appearance of your teeth? Would you like whiter or straighter teeth?
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I understand it is my responsibility to inform the doctors at the next appointment.

_____ Date: _____
Signature of patient, parent or guardian

Consent for Services

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days.

In consideration for the professional services rendered to me, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees incurred in collection of my account.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I understand that dental procedures can cause inflammation and/or changes in teeth or nerves and can lead to tooth, mouth, jaw sensitivity and/or infection. It is possible to have irreversible nerve damage from injections and/or dental procedures. Permanent numbness is a possible side effect from dental procedures and/or anesthetics. Dental anesthetic may contain epinephrine and other ingredients that may cause an increase in blood pressure and ultimately death in rare cases.
I authorize you to release my records as required to provide me with the best dental health.

I have read, understand and accept the above conditions of treatment and payment.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party