



Date _____

5640 West Broadway • Crystal, MN 55428 • (763) 537-3655

Patient's Last Name _____ First _____ M.I. _____ Marital Status _____
 Home Address _____ Apt # _____ Sex: M F Birthdate _____ Age _____
 City _____ State _____ Zip _____ Home number _____ Cell number _____
 Social Security Number _____ Where are you attending College _____ FT PT
 Occupation _____ Employer _____ Work Number _____

Account Information:

Person responsible for account _____
 Employer's address _____ City _____ Work Number _____
 Nearest relative not living with you _____ Home Number _____
 Address _____ Work Number _____

Getting to Know You:

Who may we thank for referring you? _____
 Name of your former Dentist _____
 Date of last dental examination _____
 Date of last full mouth x-ray _____
 Your physician _____ Phone _____
 Pharmacy _____ Phone _____

For Patients with Dental Insurance:

Primary Carrier

Insured Person's Name _____ Birthdate _____
 Employer _____ SS# _____
 Name of Insurance Plan _____ Group # _____

Please provide us with your insurance card

Secondary Carrier

Insured Person's Name _____ Birthdate _____
 Employer _____ SS# _____
 Name of Insurance Plan _____ Group # _____

Crystal Dental Care Medical History

- Are you now under current medical treatment? Yes No If yes, please explain _____
- Have you ever been hospitalized or had major surgery? Yes No If yes, please explain _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain _____
- What medications are you currently taking? please list _____
- Do you use tobacco? Yes No If yes, please explain _____
- Do you use controlled substances? Yes No If yes, please explain _____

For women only - Are you: Pregnant/trying to get pregnant? Nursing?

Taking oral contraceptives?

Are you allergic to any of the following? _____

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Other If yes, please explain: _____

Do you have, or have you had, any of the following? _____

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

DENTAL HISTORY

Yes No

- Do you have a toothache now?
- Do you have any growths or sore spots in your mouth?
- Do your gums bleed easily?
- Is any part of your mouth sore to pressures (including biting) or irritants? (cold, heat, sweets, etc.)

Explain _____

- Have you ever had local anesthetic? (novocaine)
- Have you ever had any adverse reaction to local anesthetics?
- Have you ever had any difficulty with dental extractions in the past? (prolonged bleeding, dry socket, etc.?)

Explain _____

- Have you ever had periodontal disease or any gum disease? _____
- Do you habitually clench or grind your teeth during the day or night?
- Do you have pain in or near your ears?
- Have you ever been instructed in proper flossing and brushing techniques?
- Do you brush and floss daily?

Consent:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aid deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connections with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent or Responsible party _____ Relationship to Patient _____