CROSBY
DENTISTRY

# PATIENT INFORMATION

Patient's Name_____
First MI Last

Address _____

City_____ State_____ Zip Code_____

Home Phone _____Cell Phone _____Work Phone_____

E-Mail Address_____

SS# _____Date of Birth_____

Please check the appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If your are a college student: ☐ Full-time ☐ Part-time Name of School:_____

Patient's or Parent's/Guardian's Employer _____

Spouse or Parent's/Guardian's Name _____

Whom may we thank for referring you to Dr. Crosby? _____

Person to contact in case of an emergency_____ Phone_____

## RESPONSIBLE PARTY INFORMATION

Name of person responsible for payment of this account _____

Relationship to patient _____ Home Phone _____ Work Phone_____

Address_____

SS# _____Date of Birth_____

Is this person currently a patient in this office? ☐ YES ☐ NO

*I authorize Dr. Crosby to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I also authorize the following person(s) to receive information regarding my treatment, diagnosis, finances, and appointments:*

_____

*I agree to be responsible for payment for all services rendered on my behalf or my dependents. If I have dental insurance, I understand that, as a courtesy to me, a staff person will be assigned to assist in attempting to verify dental insurance coverage, determine the limitations of my policy, identify the maximum dental insurance benefits, and assist in filing the necessary forms, so that benefits to which I am entitled may be received up to the maximum allowable amount. I authorize and request my insurance company to make payment directly to Dr. Brian Crosby, unless otherwise payable to me. I also understand Signature of patient or parent/guardian, if minorthat there is no guarantee of insurance coverage or payment and that my dental insurance carrier may deny payment or payless than the actual bill for services, for any reason they may choose.*

X _____ Date_____
Signature of patient or parent/guardian, if minor

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# PATIENT MEDICAL HISTORY

Patient's Name_____
First MI Last

Are you under the care of a physician? ☐ YES ☐ NO If so, reason:_____

Physician's Name_____ Phone Number_____

Date of last medical examination: _____

Do you use tobacco (cigarettes, chewing tobacco, or snuff)? ☐ YES ☐ NO If so, how many times per day?_____

If you are a female: Are you pregnant? ☐ YES ☐ NO Are you taking birth control pills? ☐ YES ☐ NO
Are you nursing? ☐ YES ☐ NO

## PLEASE LIST ANY MEDICATIONS:

Medication: _____ Milligrams _____ Reason_____

Medication: _____ Milligrams _____ Reason_____

Medication: _____ Milligrams _____ Reason_____

Medication: _____ Milligrams _____ Reason_____

Medication: _____ Milligrams _____ Reason_____

## Please indicate if you have or have had any of the following diseases or problems:

☐ Abnormal Bleeding
☐ Alcohol/Drug Abuse
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Artificial Heart Valve
☐ Asthma
☐ Blood Transfusion
☐ Cancer/Radiation/Chemotherapy
☐ Colitis/Acid Reflux/Crohn's Disease
☐ Congenital Heart Defect
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Fainting Spells
☐ Fever Blisters
☐ Frequent Headaches
☐ Glaucoma
☐ Heart Attack
☐ Heart Surgery
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV + AIDS
☐ Kidney Problems
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pace Maker
☐ Psychiatric Problems
☐ Rheumatic Fever
☐ Seizures
☐ Sickle Cell Disease
☐ Sinus Problems
☐ Stroke
☐ Taken Fen-Phen
☐ Taking Aspirin
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

## ALLERGIES — Please indicate if you have allergies:

☐ Aspirin
☐ Codeine
☐ Dental Anesthetics
☐ Erythromycin
☐ Jewelry
☐ Latex
☐ Metals
☐ Penicillin
☐ Tetracycline
☐ Other _____
☐ Other _____
☐ Other _____

## OSTEOPOROSIS MEDICATIONS

Are you taking or scheduled to begin taking osteoporosis medications? ☐ YES ☐ NO If so, which medication:

☐ Fosamax ☐ Actonel ☐ Boniva How long have you be taking this medication?_____

Have you been treated for osteoporosis, bone pain, hypercalcemia, or skeletal complications with intravenous (IV) bisphosphonates? (Aredia or Zometa) ☐ YES ☐ NO

**Signature** _____ **Date** _____

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# PATIENT DENTAL HISTORY

PATIENT'S NAME_____
First MI Last

Reason for this dental visit _____

When was your last dental visit? _____What was done? _____

How often did you visit the dentist before then? _____

Previous Dentist (Name and Location) _____

Have you had a complete series of dental x-rays/digital images taken? ☐ YES ☐ NO
If so, when? _____ Where? _____

How often do you brush your teeth? _____ How often do you floss? _____

## Please answer the following questions related to your dental health:

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | Do your gums bleed while brushing/flossing? | ☐ | ☐ | Have you ever had any prolonged bleeding following extractions? |
| ☐ | ☐ | Do you clench or grind your teeth? | ☐ | ☐ | Have you ever experienced any of the following in your jaw? Please indicate: |
| ☐ | ☐ | Are your teeth sensitive to hot or cold liquids/foods | ☐ | ☐ | Clicking? |
| ☐ | ☐ | Have you ever had periodontal (gum) treatment? | ☐ | ☐ | Difficulty chewing? |
| ☐ | ☐ | Have you ever worn a bite plate or any difficult appliance? | ☐ | ☐ | Pain in the joint, ear, or side of the face? |
| ☐ | ☐ | Have you ever had any extractions in the past? | ☐ | ☐ | Do you wear dentures or partials? |
| ☐ | ☐ | Do you have any sores or lumps in or near your mouth? | | | If "Yes", date of placement _____ |
| ☐ | ☐ | Do you feel pain in any of your teeth? | | | |
| ☐ | ☐ | Have you had any head, neck or jaw injuries? | | | |

## If you could change *ANYTHING* about your smile, what would you want to change?

_____

## PATIENT UNDERSTANDING:

*I certify that I have read and understand the Patient Information, Patient Medical History and Patient Dental History and that the information I have given on these forms is accurate. I understand the importance of a truthful health history and that providing incorrect information may be dangerous to my health. I understand that my dentist and his staff will rely on this information for treatment me. I acknowledge that my questions, if any, about inquires set forth herein have been answered to my satisfaction. I will not hold Dr. Crosby or his staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of these forms. I also give permission to Dr. Crosby or his staff to contact me concerning any and all risks associated with my decision not to complete necessary recommended treatment.*

*I understand that on occasion visiting doctors and their staff may observe procedures in Dr. Crosby's office. I also understand that necessary x-rays, models, or photographs may be taken during treatment that will be used not only for diagnosis purposes, but also for educational clinical presentations, for which I grant the following permission:*

Please initial where permission is granted:

_____ Visiting doctors or visiting staff are permitted to observe procedures provided for me.
_____ Clinical photographs, x-rays or digital images can be used for educational purposes in clinical presentations.
_____ Statements made by me can be used for educational purposes in clinical presentations.
_____ My name and/or my face can be used in clinical presentations for educational purposes.

X _____ Date_____
Signature of patient or parent/guardian, if minor

# Brian Crosby, DMD

*Your Privacy Is Important to US*

## Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Brian Crosby, D.M.D. I hereby authorize, as indicated by my signature below, Brian Crosby, D.M.D. to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Name of Child/Children, if applicable

_____ _____

Signature Date

Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number _____
- ☐ You may contact me on my mobile telephone number _____
- ☐ You may contact me on my work telephone number _____
- ☐ You many send me an email at: _____
- ☐ Other_____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Date Added / Removed:_____
2. _____Date Added / Removed:_____
3. _____Date Added / Removed:_____
4. _____Date Added / Removed:_____

***

**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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)_____

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# PATIENT INFORMED CONSENT

## Dental Insurance Benefits & Financial Responsibility
## Non-Contracted / Out-of-Network Provider

Our office is committed to transparency regarding dental insurance benefits and patient financial responsibility. Please review the following information carefully.

**1. PROVIDER STATUS**

Our practice is a non-contracted, out-of-network provider with all dental insurance plans, with the exception of Delta Dental Premier. We do not have contractual agreements with other insurance companies regarding their fee schedules, allowable charges, or reimbursement rates.

**2. INSURANCE VERIFICATION**

As a courtesy, our office makes every reasonable effort to verify insurance benefits before treatment. However, because we are non-contracted with your insurance company, we may not have full access to all plan details, exclusions, limitations, internal guidelines or reimbursement policies.

Insurance verification is an estimate of benefits only and is **NOT a guarantee of coverage or payment.** Final coverage and reimbursement decisions are made by your insurance company after claims are submitted and processed.

**3. USUAL, CUSTOMARY & REASONABLE (UCR) FEES**

Insurance companies establish their own Usual, Customary, and Reasonable (UCR) fees or allowable amounts. These amounts may differ from our office fees and do not necessarily reflect the actual cost of treatment. Your insurance may reimburse less than anticipated, even when benefits have been verified.

**4. PATIENT FINANCIAL RESPONSIBILITY**

I understand that I am financially responsible for all charges associated with treatment received, regardless of insurance payment or denial. This includes differences between office fees and insurance allowable amounts, deductibles, annual maximums, exclusions, frequency limitations, downgrades, and any services not covered by my plan.

Any insurance payment received will be credited to my account. I am responsible for any remaining balance.

**5. ACKNOWLEDGMENT & CONSENT**

By signing below, I acknowledge that I have read and understand the following:

- I understand the practice's non-contracted, out-of-network status.
- I understand that insurance verification does not guarantee payment.
- I understand that my insurance company determines its own UCR fees and reimbursement amounts.
- I accept financial responsibility for any balance not paid by my insurance company.
- I have had the opportunity to ask questions regarding my insurance benefits and financial responsibility.

This acknowledgment does not waive any rights or protections provided by applicable law.

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**PATIENT INFORMATION**

Patient Name: _____ Date of Birth: _____

Insurance Company: _____

**PATIENT / RESPONSIBLE PARTY ACKNOWLEDGMENT**

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient (if applicable): _____