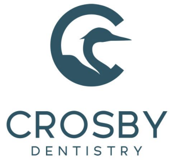

PATIENT INFORMATION

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 that 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

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:

CROSBY
DENTISTRY

☐ 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** ________________________________

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	
☐	☐	Do your gums bleed while brushing/flossing?
☐	☐	Do you clench or grind your teeth?
☐	☐	Are your teeth sensitive to hot or cold liquids/foods
☐	☐	Have you ever had periodontal (gum) treatment?
☐	☐	Have you ever worn a bite plate or any difficult appliance?
☐	☐	Have you ever had any extractions in the past?
☐	☐	Do you have any sores or lumps in or near your mouth?
☐	☐	Do you feel pain in any of your teeth?
☐	☐	Have you had any head, neck or jaw injuries?

YES	NO	
☐	☐	Have you ever had any prolonged bleeding following extractions?
☐	☐	Have you ever experienced any of the following in your jaw? Please indicate:
☐	☐	Clicking?
☐	☐	Difficulty chewing?
	☐	Pain in the joint, ear, or side of the face?
☐	☐	Do you wear dentures or partials? If "Yes", date of placement ___________________

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)____