Welcome to our office
Town Square Dental
Cindy M. Crews, D.D.S., P.C.

Patient Information (confidential)

Name _____ Birth date ____/____/____ SS#_____

Physical Address _____City _____State _____ Zip _____

Billing Address_____City_____State_____Zip_____

Home Phone (____)_____ Cell Phone (____)_____

Circle: minor single married divorced widowed separated

Occupation _____ if Student, Name of School _____

Circle: full time part time

Patient's Employer _____Work Phone (____)_____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian name _____Employer_____

Work Phone (____) _____ whom may we thank for referring you? _____

Emergency Contact Name: _____ Phone number: _____ Relation: ____

Responsible Party

Name of Person Responsible for this account _____

Relation _____ Birth date ____/____/____ Driver's License # _____

Address _____ City_____ State_____ Zip_____

Home Phone (____)_____ Cell Phone (____)_____

Employer _____ Work Phone (____)_____

Is this person currently a patient in our office? *Yes No* For your convenience, we offer the following methods of payment. Please circle the option you prefer.

Cash Personal Check Discover/ MasterCard/ Visa Care Credit

Payment is expected in full at each appointment.

Dental Insurance Information

Name of insured _____ Relation _____

Birth date ____/____/____ SS# _____ Name of Employer _____

Address _____ City _____ State_____ Zip _____

Work Phone (____)_____ Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Do you have any additional **dental** insurance? *Yes No* If yes, complete the following:

Name of insured _____ Relation _____

Birth date ____/____/____ SS# _____ Name of Employer _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Patient Health History

Patient Name _____ Date of Birth _____

Welcome to our office! Please fill out this detailed medical history so we are aware of any problems you may have or have had in the past. If there is anything medically NOT listed on this form, please use the "Additional comments" section to write in any other information. Thank you.

What Pharmacy would you like to use _____

Primary reason for this appointment_____

Name of your Physician(s) _____

Physician(s) phone numbers _____

Date of last visit to physician(s) _____

Are you in good health? _____

Have you EVER been hospitalized or had any surgeries? If so, list for what and dates. _____

_____

_____

_____

Are you taking any prescriptions (including over the counter) If so, please list them and what you are taking them for _____

_____

_____

Do you currently have or have you had any of the following in the past?

1. Damaged Heart Valves, artificial valves or heart murmur? ..... Yes NO
2. Rheumatic Heart Disease..... Yes NO
3. Arteriosclerosis ..... Yes NO
4. High blood pressure ..... Yes NO
5. Heart trouble, heart attack, angina, or any other heart related condition ..... Yes NO
6. Chest pain on exertion ..... Yes NO
7. Shortness of breath after mild exercise ..... Yes NO
8. Do your ankles swell ..... Yes NO
9. Allergies to foods, plants, latex, etc ..... Yes NO

   Please list _____

   _____

10. Sinus trouble ..... Yes NO
11. Asthma or hay fever ..... Yes NO
12. Fainting spells or seizures ..... Yes NO
13. Diabetes ..... Yes NO

14. Hepatitis, jaundice or liver disease ..... Yes NO
15. Frequent or reoccurring mouth sores ..... Yes NO
16. Thyroid problems ..... Yes NO
17. Respiratory problems ..... Yes NO
18. Arthritis or painful/swollen joints ..... Yes NO
19. Stomach ulcer or hyperacidity ..... Yes NO
20. Kidney trouble ..... Yes NO
21. Tuberculosis ..... Yes NO
22. Persistent couch or cough that produces blood ..... Yes NO
23. Persistent swollen neck glands ..... Yes NO
24. Epilepsy or neurological disorder ..... Yes NO
25. Problems with mental health ..... Yes NO
26. Cancer ..... Yes NO
27. Compromised immune system ..... Yes NO
28. Glaucoma ..... Yes NO
29. Joint replacement ..... Yes NO
30. Osteoporosis ..... Yes NO
31. HIV Virus/ AIDS ..... Yes NO
32. Any abnormal bleeding ..... Yes NO
33. Have you ever had a blood transfusion ..... Yes NO
34. Anemia or other blood disorder ..... Yes NO
35. Have you ever had treatment for a tumor or growth ..... Yes NO

Are you allergic or have you had a reaction to:

Local Anesthetics ..... Yes NO
Penicillin or antibiotics ..... Yes NO
Sulfa drugs ..... Yes NO
Barbiturates or sleeping medication ..... Yes NO
Asprin ..... Yes NO
Iodine ..... Yes NO
Codeine or other narcotics ..... Yes NO
Other medical condition not listed above, please list _____

_____

Do you now or have you ever used tobacco products ..... Yes NO
Have you ever had complications with previous dental treatment ..... Yes NO
If yes, please explain _____
Do you wear contact lenses ..... Yes NO
Are you wearing removable dental appliances ..... Yes NO

Do you snore at night?	Yes	NO
Do you use a CPAP	Yes	NO
Was it ever recommended to use a CPAP at night?	Yes	NO
Has anyone ever told you that you snore?	Yes	NO

Women:

Are you pregnant ……..	Yes	NO
Are you nursing ……..	Yes	NO

Additional comments _____

_____

_____

Additional questions you have for the dentist _____

_____

_____

24 business hours is required to cancel any appointments in our office. A $50 cancellation fee will be assessed to your account. If your appointment is canceled the day of, there will be a $100 cancelation fee assessed. These fees are not a refundable fee.

If you are scheduling treatment there is a deposit required of half (1/2) of your patient portion due prior to scheduling.

Balance is due at the time service is rendered unless other arrangements have been made previously. We file with Insurance as a courtesy; however, if Insurance doesn't submit payment or is denied for any reason, it is ultimately the patient's responsibility.

I certify that I have read and understand the above information and have been as thorough as possible. I have accurately answered all questions correctly to the best of my knowledge. I understand that providing false information could be dangerous to my health. I will not hold my dentist or any staff member responsible for an error or omission that I may have made in completing this document.

_____	_____	_____
Print Patient Name	Signature of patient or guardian	Date