

# Patient Information

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

## PERSONAL

Name: \_\_\_\_\_  
Last First MI (Preferred)

Birthdate: \_\_\_\_\_ SS #: \_\_\_\_\_ Gender:  M  F Married:  Y  N

Work Phone: \_\_\_\_\_ Wireless Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Contact Method:  HmPhone  WkPhone  WirelessPh  Email  TextMessage

Preferred Contact Method for Confirmations:  HmPhone  WkPhone  WirelessPh  Email  TextMessage

Preferred Contact Method for Recall:  HmPhone  WkPhone  WirelessPh  Email  TextMessage

Student status if dependent over 19 (for ins):  Nonstudent  Fulltime  Parttime

How did you hear about us?

\_\_\_\_\_  
(If someone referred you here, please enter their name so we can thank them.)

## ADDRESS AND HOME PHONE

Check box if same for entire family:

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

## INSURANCE POLICY 1

Your Relationship to Subscriber:  Self  Spouse  Child

Subscriber Name: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Please present insurance card to receptionist.

## INSURANCE POLICY 2

Your Relationship to Subscriber:  Self  Spouse  Child

Subscriber Name: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Please present insurance card to receptionist.

# Medical History

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ City/State: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## List all medications that you are now taking:

**\*\*EXISTING PATIENTS\*\*** Check the box next to any medication no longer being taken.

- |                                   |                                    |
|-----------------------------------|------------------------------------|
| 1. <input type="checkbox"/> _____ | 6. <input type="checkbox"/> _____  |
| 2. <input type="checkbox"/> _____ | 7. <input type="checkbox"/> _____  |
| 3. <input type="checkbox"/> _____ | 8. <input type="checkbox"/> _____  |
| 4. <input type="checkbox"/> _____ | 9. <input type="checkbox"/> _____  |
| 5. <input type="checkbox"/> _____ | 10. <input type="checkbox"/> _____ |

## Are you allergic to any of the following?

Y N

Anesthetic

Aspirin

Codeine

Ibuprofen

Other allergies not listed above: \_\_\_\_\_

Y N

Iodine

Latex

Penicillin

Sulfa

Peanut

## Do you have any of the following medical conditions?

Y N

Asthma

Bleeding Problems

Cancer

Diabetes

Heart Murmur

Heart Trouble

High Blood Pressure

Joint Replacement

Other conditions not listed above: \_\_\_\_\_

Y N

Kidney Disease

Liver Disease

Pregnancy

Psychiatric Treatment

Rheumatic Fever

Sinus Trouble

Stroke

Ulcers

Tobacco use? If so, what kind and how much? \_\_\_\_\_

Unusual reaction to dental injections? \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_ Are you in pain? \_\_\_\_\_

## New Patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? \_\_\_\_\_

Do you have BiteWing x-rays that are less than 1 year old? \_\_\_\_\_

Name of former Dentist: \_\_\_\_\_ City/State: \_\_\_\_\_

Date of last cleaning and exam: \_\_\_\_\_

Patient / Legal Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Dental Patient Screening Form

**Patient Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_  
(First) (Last)

	<b>Pre-Appointment Self-Assessment</b> Date: _____	<b>OFFICE USE ONLY</b> Date: _____
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they experienced recent loss of taste or smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they in contact with any confirmed COVID-19 positive patients? <b>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your/their age over 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.**

# Dental History Form

Why are you changing your dentist  
(if applicable)?

---

When was your last visit to the dentist?

---

How did you find "Healthy Crowns Dentistry" ?

---

What's the reason(s) for your visit?

---

Do you like your smile? If not, what changes to  
your smile would you like to have done?

---

Do you know of areas of soreness, or irritation in  
your mouth?

---

Do you know, or think you have a habit of teeth  
grinding?

---

Are your teeth sensitive to hot / cold temperatures?

---

Have you ever had complications after a dental  
treatment?

---

Are there anything about your dental health, and  
concerns that you want us to know?

---

Have you ever had unfavorable / allergic reactions  
to local anesthetics?

---

Do your gums bleed when you brush or floss?

---

Have you ever been treated for Periodontal Infections?

---

How often do you brush, and/or floss?

---

Have you ever had a experience at a dental office?

---

Print Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient / Legal Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appointment Cancellation Policy

Welcome to Healthy Crowns Dentistry (HCD)! It is our pleasure to have the privilege of helping you, our valued patient, achieve a healthy state of oral health. In order for us to provide excellent dental-care for you, we need to ensure that the time allotted to you is available and guaranteed on your behalf. When an appointment is scheduled under your name, we need your help to keep your appointment.

We understand that unforeseen circumstances can occur that would make you unavailable for your scheduled appointment. You are welcome to cancel your scheduled appointment, as long as the cancellation is made at least (24) twenty-four hours prior to the appointment.

Please understand that a no-show, or failure to notify the office staff at least 36-hours in advance of the appointment time will incur a \$35.00 charge. You will not be able to reschedule another appointment until the 'cancellation fee' has been paid to HCD.

I have read and understand the 'Appointment Cancellation Policy', and have agreed to the terms and conditions stated above. I also understand and agree that such terms, and conditions may be subjected to change at any time by the HCD's management team.

Print Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient / Legal Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Consent to Electronic Communications Via Gmail/Fax/Text Messages

Healthy Crowns Dentistry uses email, fax, and text messages as our primary means to send Individually Identifiable Health Information (IIHI), and appointment reminders. HCD uses Gmail for our email communication. There are risks that any Individually Identifiable Health Information, and other sensitive or confidential data that may be contained in such emails, fax, and text messages may be misdirected, disclosed or intercepted by unauthorized third parties.

You may, or may not grant consent to receive emails, fax, and text messages from us regarding your treatment. We will use the minimum necessary amount of protected health information in any form of electronic communication.

I understand I can add or withdraw my consent at any time.

I consent and accept the risks of receiving 'IIHI, FAX & APPOINTMENT REMINDERS' by Gmail, fax and/or text messages.

I consent and accept the risks of receiving ONLY 'APPOINTMENT REMINDERS' by Gmail and/or text messages.

I do not consent to receiving ANY communications by Gmail or fax.

Print Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient / Legal Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Notice of Privacy Policies

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Date: \_\_\_\_\_

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Signature: \_\_\_\_\_