crossroads
FAMILY DENTISTRY

Patient Information and Medical/Dental History

Please fill out as accurately as possible. Please print.

Personal Information

Date: _____ Patient Name: _____

Social Security Number: _____ Date of birth: _____

Gender: ☐Male ☐Female ☐Married ☐Single ☐Other

If patient is a minor, Parent/Legal guardian name: _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip code: _____

Home phone: (____) _____ Work Phone: (____) _____

Cell phone :(____) _____ Email: _____

How did you find our office?

☐Online/Google ☐Insurance ☐Location ☐Friend/Family

☐Other: _____

Insurance Information – Please list information for the PRIMARY POLICY HOLDER below

I do not have insurance: ☐ I have dual insurance: ☐

Insurance company: _____ Employer: _____

Primary policy holder: ☐ Self Spouse/Parent: ☐ Policy holder DOB: _____

Policy holder name: _____

Social Security Number: _____ Group #: _____

Identification #: _____

HIPPA Patient Consent

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, at anytime. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). A detailed description of the HIPPA policy is available for your review upon request.

May we leave a recorded message regarding your financial responsibilities, or dental appointments on your home or cell phone number as provided? **YES** ☐ **NO** ☐

May we contact you by text or email regarding your appointment reminders?
YES ☐ **NO** ☐

_____ **Date:** _____

Signature of patient, parent or guardian

Consent for Treatment

I, _____, authorize the providers at Crossroads Family Dentistry, to perform any necessary dental services with my informed consent and assume all risks associated with treatment in the hope of achieving better dental and physical health.

I understand there are certain risks associated with the use of local anesthetic which can lead to bruising, muscle soreness, cardiac stimulation, and temporary or even permanent numbness to the lips or tongue. After lengthy appointments jaw muscles may be sore or tender. Gums and soft tissues may also be sensitive or painful during or after treatment. Although rare, it is possible for the tongue, cheeks, or other oral tissues to be inadvertently abraded or lacerated during routine dental procedures.

I understand, that as part of dental treatment items including, but not limited to, crowns, small dental instruments, drill components, and the like, may be aspirated or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may in rare cases, require sophisticated medical procedures by a licensed physician to remove safely.

_____ **Date:** _____

Signature of patient, parent or guardian

Office Financial Policy

Our office provides insurance benefits checks, as well as claim submission, as a courtesy to our patients. We work for the health of our patients, not to benefit their insurance company. Therefore we help our patients maximize their insurance benefits; however we do not guarantee that all services recommended will be covered by your particular insurance plan.

1. Co-payments for services rendered are due at time of service.

2. We accept cash, personal checks, and all major credit cards.

3. We offer Care Credit as a courtesy to our patients, however rules and regulations apply.

4. For returned or canceled checks, a fee of $40 will be applied to your account.

5. As a courtesy to patients who may be waiting for an appointment, our office has *cancelation fee of $50*, for missed or failed appointments. This fee applies when:
    a. An appointment is canceled with less than 48 hours notice
    b. An appointment is missed without first alerting the office (no show, no call).

6. If you fail 3 or more appointments in a 12 month period, you may be dismissed from the practice. An appointment will be considered “failed” if:
    a. An appointment is canceled with less than 24hours notice repeatedly
    b. A patient no show’s for scheduled appointments

I, _____, authorize Crossroads Family Dentistry to bill my dental insurance, and use my personal health information as necessary for billing purposes. I request my dental insurance to pay Crossroads Family Dentistry directly for services rendered. I understand that my dental insurance carrier may pay less than the actual bill for services, and that I am ultimately responsible for payment of dental services rendered on my behalf.

I understand that co-payments are due at time of services rendered, in full, unless prior arrangements have been made, and documented.

I understand the above listed cancelation/failed appointment policy, and will do my utmost to comply.

_____ **Date:** _____

Signature of patient, parent or guardian

The following information is required to accurately diagnose any condition, and to give you the highest possible standard of professional services. Please be as honest, and accurate as possible.

How often do you brush your teeth?
□Less than 1x per day □1x per day □2x per day □3x per day

How often do you floss?
□ 1x per day □1-3x per week □4-6x per month

Do you have any teeth that are bothering you? YES □ NO□
If yes, please list:

_____

_____

Do you have any allergies?
□ None□ Penicillin □ Asprin □ Nsaids □ Local Anesthetics □ Acrylic □Latex

□ Sulfa □ Codeine □ Metal □ Seasonal □ Other: please list below

List any medications you are currently taking:

Have you had any recent surgical procedures? Yes☐ No☐
If yes, please list below:

Have you had joints replaced? Yes☐ No☐
If yes, please list which joints, and when they were replaced below

Are you pregnant? Yes ☐ No ☐
If yes, what is your due date? _____/_____

Are you currently experiencing any of the conditions listed below?

	YES	NO
Arthritis	☐	☐
Asthma	☐	☐
Anxiety	☐	☐
Cancer	☐	☐
Hay fever	☐	☐
Anemia	☐	☐
Diabetes	☐	☐
Blood disorder	☐	☐
Fainting spells	☐	☐
Sinus trouble	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐
Nervous disorder	☐	☐
Blood pressure problems High/Low	☐	☐
Kidney disease	☐	☐
Congenital heart disorder or heart murmur	☐	☐
Hepatitis (A,B,C), jaundice, or liver disease	☐	☐
HIV Infection/AIDS	☐	☐
Lung or breathing disorder	☐	☐
Rheumatic fever, Scarlet fever	☐	☐
Seizures e.g. epilepsy or stroke	☐	☐
Do you have a history of substance abuse?	☐	☐
Are you currently using recreational drugs?	☐	☐
Do you smoke, or chew tobacco?	☐	☐

If yes: how much? _____

If you answered YES to any of the above medical conditions, please explain any further details regarding said condition:

Are you currently experiencing any conditions/illnesses that are NOT listed above? If yes list them below:

I attest that the above listed health information is accurate to the best of my knowledge. I have informed my provider of any pre-existing medical conditions, allergies, or medications that may affect their treatment of me.

Patient Signature: _____ **Date:** _____