PATIENT INFORMATION FOR THE PRACTICE OF JENNIFER L. CRANDALL, DDS

DATE ____________________

PATIENT NAME	GENDER	DATE OF BIRTH	
ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE	
EMAIL ADDRESS	SS#	CA DL#	
PERSON RESPONSIBLE FOR ACCOUNT	ADDRESS	PHONE	
OCCUPATION	EMPLOYED BY	PHONE	
EMERGENCY CONTACT (relationship)	ADDRESS	PHONE	
SPOUSE NAME	SPOUSE SS#	SPOUSE DOB	
WHOM MAY WE THANK FOR REFERRING YOU?			

MEDICAL HISTORY

CURRENT PHYSICIANS NAME:	ADDRESS:	PHONE:
ARE YOU UNDER CURRENT CARE?	IF SO, PLEASE EXPLAIN:	
HOSPITALIZED IN THE PAST 5 YEARS?	IF SO, PLEASE EXPLAIN:	

DESCRIBE YOUR PRESENT HEALTH (CIRCLE) GOOD FAIR POOR DON'T KNOW

ARE YOU TAKING ANY MEDICATIONS INCLUDING NON-PRESCRIPTION **YES NO**

BISPHOSPHONATES____________________ **YES NO**

PRESCRIBED: ____________________

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OVER THE COUNTER: ____________________

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VITAMINS, NATURAL OR DIET SUPPLEMENTS:

DO YOU HAVE / HAD / OR BEEN TREATED FOR ANY OF THE FOLLOWING

ALLERGIES OR REACTIONS TO DRUGS	**YES**	**NO**	**NEUROLOGICAL PROBLEMS**	**YES**	**NO**
PLEASE LIST ____________	YES	NO	RADIATION TREATMENTS	YES	NO
ALLERGIES TO ANESTHETICS	**YES**	**NO**	**ARTHRITIS**	**YES**	**NO**
ALLERGY TO LATEX	YES	NO	ASTHMA	YES	NO
ANY HEART AILMENT	**YES**	**NO**	**HAY FEVER/ALLERGIES**	**YES**	**NO**
HEART MURMUR	YES	NO	DIABETES	YES	NO
RHEUMATIC FEVER	**YES**	**NO**	**KIDNEY PROBLEMS**	**YES**	**NO**
HIGH BLOOD PRESSURE	YES	NO	LIVER PROBLEMS	YES	NO
EXCESSIVE BLEEDING FROM CUTS	**YES**	**NO**	**HEPATITIS**	**YES**	**NO**
ANEMIA OR BLOOD PROBLEMS	YES	NO	MALIGNANCIES	YES	NO
STROKE	**YES**	**NO**	**SINUS PROBLEMS**	**YES**	**NO**
FAINTING	YES	NO	TUMOR	YES	NO
EPILEPSY	**YES**	**NO**	**THROAT OR EAR PAIN**	**YES**	**NO**
LUNG DISEASE	YES	NO	JOINT REPLACEMENT	YES	NO
THYROID PROBLEMS	**YES**	**NO**	**PSYCHIATRIC/EMOTIONAL PROBLEMS**	**YES**	**NO**
EYE DISORDERS	YES	NO	VENEREAL DISEASE	YES	NO
TONSILLITIS	**YES**	**NO**	**ARC/AIDS/HIV DISEASE**	**YES**	**NO**
TUBERCULOSIS	YES	NO	PREVIOUS/CURRENT PHEN-FEN	YES	NO
ULCER OR COLITIS	**YES**	**NO**	**PREGNANCY** IF SO, WHAT MONTH ________	**YES**	**NO**

IS THERE ANY OTHER INFORMATION WE SHOULD KNOW ABOUT YOUR HEALTH? EXPLAIN:

PATIENTS NAME ________________________________ **DATE** ______________________________

DENTAL HISTORY

PRIMARY DENTAL CONCERN:	
IS THERE ANYTHING IN YOUR DENTAL APPEARANCE YOU WOULD LIKE TO CHANGE?	
WHAT IS YOUR OWN GENERAL IMPRESSION OF YOUR TEETH?	
DATE OF LAST DENTAL EXAM & X-RAYS?	**DATE OF LAST CLEANING**
ANY MEDICAL/PHYSICAL PROBLEMS OR BAD EXPERIENCES DURING PAST DENTAL VISITS? PLEASE EXPLAIN	

DO YOU HAVE OR USE ANY OF THE FOLLOWING

FEARS REGARDING DENTAL TREATMENT	**YES**	**NO**	**FOOD IMPACTION**	**YES**	**NO**
USING ANTIBIOTICS PRIOR TO TREATMENT	YES	NO	NITROUS OXIDE (GAS)	YES	NO
WORRY OFTEN ABOUT YOUR TEETH	**YES**	**NO**	**DAILY FLOSSING**	**YES**	**NO**
INTEREST IN KEEPING YOUR TEETH	YES	NO	TOOTHPICKS	YES	NO
PERIODONTAL TREATMENT	**YES**	**NO**	**LOOSE TEETH**	**YES**	**NO**
ORTHODONTIC TREATMENT	YES	NO	FRACTURED TEETH	YES	NO
FINGERNAIL BITING	**YES**	**NO**	**SORES IN YOUR MOUTH**	**YES**	**NO**
CLENCHING OR GRINDING	YES	NO	BLEEDING GUMS	YES	NO
DIFFICULTY OPENING/CLOSING MOUTH	**YES**	**NO**	**TOBACCO**	**YES**	**NO**
PAIN OR CLICKING IN JAW JOINTS	YES	NO	GUM DISEASE	YES	NO
ANY INJURIES TO JAW OR MOUTH	**YES**	**NO**	**ANY TEETH SENSITIVE TO:**		
FREQUENT HEADACHES	YES	NO	HOT	YES	NO
PROBLEMS BREAKING OR LOSING FILLINGS	**YES**	**NO**	COLD	YES	NO
SWELLING OR LUMPS IN MOUTH	YES	NO	SWEETS	YES	NO
BAD BREATH/UNPLEASANT TASTE	**YES**	**NO**	PRESSURE	YES	NO
COMPLICATIONS FROM EXTRACTIONS	YES	NO	**FREQUENT PROFESSIONAL CLEANINGS**		
ORAL HYGIENE INSTRUCTIONS GIVEN BY DDS	**YES**	**NO**	HOW OFTEN ________________________		

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of 48 hours. This fee covers only a portion of the overhead such as salaries, utilities, rent, etc. Which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient, and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies upon receipt of full (or partial) payment of bill, we do not render our services on the basis that insurance companies will pay all our fees.

PAYMENT: I _____________________________, acknowledge full responsibility for the payment of services rendered and agree to pay for them in full at the time of service, unless other arrangements are made by the finance department.

CONSENT: To my knowledge, the above information is correct and complete. I agree to all office policies listed above. I read and understand English and the terminology used on this form. I consent to treatment as necessary or desirable including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory x-ray, or other studies that may be used by the attending doctor or qualified designate.

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Patient Signature **Date**