

David D. Crane, DDS

PATIENT INFORMATION FOR DEPENDANTS

Patient Name _____ Preferred Name _____ Sex _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Physician Name _____ Birthdate _____ Age _____
Who/what can we thank for referring you to our office? _____
School Name _____ Grade _____ Sports/Hobbies _____

FATHER'S INFORMATION

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
E-mail Address _____
Birthdate _____

EMPLOYER INFORMATION

Name _____
Address _____
City _____ State _____ Zip _____
Occupation _____

DENTAL INSURANCE COMPANY

Policyholder: Self _____ Spouse _____ Other _____
Name _____
Address _____
City _____ State _____ Zip _____
Insurance Phone _____ ext. _____
Insurance ID # _____
Group ID # _____
Social Security Number _____

(For Insurance Purposes Only)

MOTHER'S INFORMATION

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
E-mail Address _____
Birthdate _____

EMPLOYER INFORMATION

Name _____
Address _____
City _____ State _____ Zip _____
Occupation _____

DENTAL INSURANCE COMPANY

Policyholder: Self _____ Spouse _____ Other _____
Name _____
Address _____
City _____ State _____ Zip _____
Insurance Phone _____ ext. _____
Insurance ID # _____
Group ID # _____
Social Security Number _____

(For Insurance Purposes Only)

Primary Insurance to be submitted first? Mother's _____ Father's _____

CREDIT INFORMATION

We do offer a cash savings if you pay for your services with a check or cash on the same day as your treatment. Payment is expected within 30 days of service unless otherwise arranged. Please discuss with the front office if you would like to establish credit with our office. Billing charges of 1 1/2% (18% annually) are added to overdue accounts (90 days). We do reserve the right to report delinquent accounts to the Credit Bureau.

MEDICAL HISTORY

Yes / No ___ Is the patient in good health? Approximate date of last medical exam? _____

Yes / No ___ Is the patient under the care of a physician? If so, explain _____

Yes / No ___ Is patient presently taking any medication? If so, please list _____

Yes / No ___ Is the patient allergic to anything? If so, please list _____

Yes / No ___ Does the patient need to be pre-medicated with antibiotics for dental appointments? _____

Yes / No ___ Is the patient pregnant or taking birth control pills? _____

Yes / No ___ Does the patient smoke or have a drug addiction? _____

Does the patient have any history of: (please circle)

AIDS / HIV	Diabetes	Hemophilia	STD	Respiratory Disease
Cancer / Tumors	Heart Disease	Nervous Disorders	Blood Disease	Cold Sores
GI Disorder	Liver Disease	Asthma / Emphysema	Fainting	Eating Disorder
Kidney Disease	Tuberculosis	Epilepsy	High/Low B Pressure	
Scarlet Fever	Arthritis	Hepatitis	Stroke	
Anemia	Endocrine Disorders	Prolonged Bleeding	Psychiatric Treatment	

Yes / No ___ Are you aware of any other diseases, conditions, or problems not listed above that we should know about?

If yes, what? _____

DENTAL HISTORY

Yes / No ___ Were you satisfied with your previous dentist? Approximate date of last dental visit? _____

Yes / No ___ Does the patient have any pain, problems, or other concerns now? _____

Yes / No ___ Has the patient's mouth, face, or teeth been injured by a fall or accident?

Yes / No ___ Is the patient taking fluoride tablets or in the drinking water?

Yes / No ___ Is the patient aware of any gum problems, bad breath, or bleeding when brushing?

Yes / No ___ Has the patient's tonsils or adenoids been removed?

Yes / No ___ Does the patient have or ever had any of the following habits? (please circle)

- Cheek, Tongue or Lip Chewing, Mouth Breathing, Clenching Teeth, Gum Chewing, Grinding Teeth,
- Thumb Sucking, Finger Nail Biting, Tongue Thrusting, Speech Problems

Yes / No ___ Is the patient apprehensive about the dental visit?

Yes / No ___ Have any other family members been treated in our office?

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist 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 payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of parent or guardian _____ Date: _____

Note to parents: Please see our web site for a lot of information on children's dental health. Kids do better when the parents remain in the waiting room during treatment.