PATIENT INFORMATION

Name:_____ _____ **I prefer to be called:**_____

Home Phone:_____ **Cell Phone:**_____ **E-Mail:**_____

Home Address:_____
STREET CITY STATE ZIP CODE

Birth Date:_____ **Patient's Age:** _____ **Sex: M / F** **Social Security #:**_____

Place of Employment:_____ **Telephone:**_____

Business Address:_____
STREET CITY STATE ZIP CODE

Marital Status: _____**Single** _____**Married** _____**Separated** _____**Widowed** _____**Divorced**

Spouse's Name:_____ **Spouse's DOB:**_____ **Spouse's SSN#:**_____

Spouse Employed By:_____**Telephone:**_____

How did you hear about our office (please circle)? **Friend or relative** **Insurance Company** **Our Website** **Drove by the office**

Search Engine (google,etc.) **Advertisement** **Other:**_____

If referred, who may we thank?_____

INSURANCE INFORMATION

(please provide a copy of your insurance card)

Policy Holder:_____**Insurance Company:**_____

Policy Number:_____ **Employer:** _____

INSURANCE AUTHORIZATION AND CONSENT FOR TREATMENT

All of the above information is correct to the best of my knowledge. I authorize use of this form on all of my insurance submissions and I authorize the release of information to my insurance company(s). I understand that I am responsible for my bill. I authorize Crawfordsville Family Dentistry and the office of Dr. Scott Frey to act as my agent in helping me to obtain payment from my insurance company. I authorize payment to Crawfordsville Family Dentistry / Dr. Scott Frey. I permit a copy of this authorization to be used in place of the original. I give this dental office, its employees, and/or other agents express prior consent to contact me at any/all phone numbers (by phone call or text message) and e-mail addresses, for the purpose of appointment reminders, treatment, insurance or payment.

I hereby authorize Dr. Frey or his designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor in order to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr. Frey to perform all recommended treatment which has been mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications to make my visit more comfortable. I understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I have read, understood and agree to the above information.

_____

PATIENT SIGNATURE **DATE**

MEDICAL HISTORY

Name of Family Doctor:_____ **Telephone:**_____

1. Are you under medical treatment now? If so, for what condition(s)? _____

_____

2. Are you currently taking any medications? If so, please list: _____

_____

_____

3. Are you allergic to any medications? If so, please list:_____

4. Do you use tobacco in any form? If yes, how much?_____

5. (Women) are you pregnant? If yes, what is your due date?_____

6. Have you ever had trouble with bleeding after surgery? _____**Yes** _____**No**

7. Do you have or have you ever had any of the following conditions? (please check all that apply)

___ **High Blood Pressure**	___ **Kidney or Liver Disease**	___ **Anemia**	___ **Psychiatric Treatment**
___ **Prosthetic Heart Valve**	___ **Infectious Disease (TB, HIV, AIDS)**	___ **Diabetes**	___ **Cancer**
___ **Bacterial Endocarditis**	___ **Any Blood Diseases**	___ **Stroke**	___ **Radiation Treatment**
___ **Cardiac Valvulitis**	___ **Asthma**	___ **Seizures**	___ **Chemotherapy**
___ **Latex Allergy**	___ **Artificial Joints Or Limb**	___ **Arthritis**	___ **Acid Reflux**

___ **Congenital Heart Disease (Other Than Mitral Valve Prolapse)** **Other:**_____

8. Do you require antibiotic pre-medication for your dental work? If yes, what condition?_____

9. Is there any other information that we should know about your health? Please describe: _____

_____

10. If necessary, may we contact your medical doctor regarding your care? _____**Yes** _____**No**

11. Do you wish to talk to the dentist privately about any problems or concerns? _____**Yes** _____**No**

12. What is your pharmacy of choice if we need to call in any prescriptions? _____

DENTAL HISTORY

1. What is the reason for your for your visit today?_____

2. What is the best description of your past dental treatment? Please check one of the following:

___ At Least 2 Visits A Year ___ At Least Once A Year ___ Only When I Have A Problem ___ About Once Every 2 – 3 Years

3. If you have ever had a bad dental experience, please describe:_____

4. If you are nervous about dental treatment, please explain:_____

5. Would you be interested in taking a pill to relax you for dental treatment (oral sedation)? _____Yes _____No

6. Have you ever had an adverse reaction to dental anesthetic? If yes, please describe:_____

7. Do you have any upcoming event or circumstances (such as weddings, major surgeries, losing insurance, etc.) that we should or need to know about? If so, what and when?_____

GUM DISEASE

8. Do you experience frequent bad breath? _____Yes _____No

9. Do your gums bleed when you brush or floss your teeth? _____Yes _____No

10. Have you ever been diagnosed with gum disease (periodontal disease)? _____Yes _____No

TMJ/SLEEP APNEA

11. Do you have any problems with the following? Check all that apply:_____Sleepiness _____Tension Headaches

_____Sore Teeth _____Problems with your jaw joint (pain, locking, clicking, limited opening, etc.)

12. Have you ever worn a mouthguard or bite appliance? _____Yes _____No

13. Have you ever been diagnosed with Sleep Apnea or participated in a sleep study? _____Yes _____No

14. Do you snore or have been told you stop breathing in your sleep (gasp for air)? _____Yes _____No

SMILE/FACIAL ESTHETICS

15. Is there anything you would like to change about your teeth or smile? If so, what? _____

16. Do you have any broken or missing teeth that you would like to have fixed or replaced? _____Yes _____No

17. Are you interested in any of the following? Check all that apply:

_____Straighter Teeth (with Clear Braces) _____Closing Spaces _____Whiter Teeth _____White Fillings

18. Have you ever had any type of facial injectables like Botox or Dermal Fillers? _____Yes _____No

19. Are you interested in reducing frown lines, forehead lines or smile lines around the eyes? _____Yes _____No

20. Are you interested in talking with the doctor about your options for botox and/or fillers? _____Yes _____No

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All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. I understand that this information is necessary to provide me with dental care in a safe and efficient manner.

_____ _____ _____ _____

PATIENT SIGNATURE **DATE** **DENTIST SIGNATURE** **DATE**