

# DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

## BRENT CRAWFORD, DDS, PA

16525 Birkdale Commons Pkwy.

Suite 300

Huntersville, NC 28078

Telephone: (704) 895-5850

Fax: (704) 895-9808

Date \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

### PATIENT INFORMATION

Name \_\_\_\_\_ SS/HIC/Patient ID # \_\_\_\_\_  
Last Name First Name Middle Initial  
Address \_\_\_\_\_ E-mail \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years  
Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer/School Address \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

### PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_ Last Name First Name Middle Initial  
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address (If different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_

### ADDITIONAL INSURANCE

Is patient covered by additional insurance?  Yes  No  
Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Address (If different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber Employed by \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)  
Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.  
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

# DENTAL HEALTH HISTORY (Confidential)

## DENTAL HISTORY

Reason for Today's Visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

Address \_\_\_\_\_

Check (✓) if you have had problems with any of the following

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.)  Yes  No

Have you had any serious illnesses or operations? \_\_\_\_\_ If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have or have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |

### MEDICATIONS

List medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

### ALLERGIES

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Sulfa       |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Latex _____ |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local Anesthetic              | _____                                |
| <input type="checkbox"/> Penicillin                    |                                      |

## SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date \_\_\_\_\_ Signature \_\_\_\_\_