

PATIENT INFORMATION

Name				Birthdate	Sex	Marital Status	
Last	First	MI					
Address				City	Zip	State	SSN#
Street							
Employer				Occupation			

Check the best method of communication:

<input type="checkbox"/> Cell Phone	<input type="checkbox"/> SMS	<input type="checkbox"/> Home Phone	<input type="checkbox"/> Work Phone	<input type="checkbox"/> Email
-------------------------------------	------------------------------	-------------------------------------	-------------------------------------	--------------------------------

Emergency Contact Information:

Name	Cellphone	Home Phone	Email
Whom may we thank for referring you?			

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Insurance Company	Subscriber ID No. or SSN#	Group Number
Subscriber's Name (if different from patient)	Subscriber's Birthdate	Relationship to Subscriber

Secondary Dental Insurance

Insurance Company	Subscriber ID No. or SSN#	Group Number
Subscriber's Name (if different from patient)	Subscriber's Birthdate	Relationship to Subscriber

DENTAL HISTORY

What would you like us to do today?	Are you in dental discomfort? <input type="checkbox"/> Y <input type="checkbox"/> N
Former Dentist	Dentist's Email
Address	Phone
Date of last dental care	Date of last x-rays

Check yes or no if you have had problems with any of the following:

Bad Breath	<input type="checkbox"/> Y <input type="checkbox"/> N	Grinding or Clenching Teeth	<input type="checkbox"/> Y <input type="checkbox"/> N	Sensitivity to hot	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding Gums	<input type="checkbox"/> Y <input type="checkbox"/> N	Loose teeth or Broken Fillings	<input type="checkbox"/> Y <input type="checkbox"/> N	Sensitivity to sweets	<input type="checkbox"/> Y <input type="checkbox"/> N
Clicking or Popping Jaw	<input type="checkbox"/> Y <input type="checkbox"/> N	Periodontal Treatment	<input type="checkbox"/> Y <input type="checkbox"/> N	Sensitivity when biting	<input type="checkbox"/> Y <input type="checkbox"/> N
Food collection between teeth	<input type="checkbox"/> Y <input type="checkbox"/> N	Sensitivity to cold	<input type="checkbox"/> Y <input type="checkbox"/> N	Sores or growths in mouth	<input type="checkbox"/> Y <input type="checkbox"/> N

How often do you brush?	How do you feel about the appearance of your teeth?
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?	<input type="checkbox"/> Y <input type="checkbox"/> N
Other information about your dental health or previous treatment?	

MEDICAL HISTORY

Physician's Name _____ Phone _____ Date of Last Visit _____

Are you currently under physician care? Y N If yes, describe _____
 Have you ever used a biphosphonate medication Y N if yes, brand? Fosamax, Actonel, Atelvia, Didronel and Boniva
 Have you ever taken Fen-Phen/Redux? Y N
 Do you use tobacco (including e-cigs)? Y N
 Do you snore or have been told that you snore? Y N
 Have you ever had a sleep study? Y N If yes, when? _____
 Do you wear a C-PAP or have been told to? Y N

Women: Pregnant Y N | Nursing Y N | Trying to get pregnant Y N

Are you allergic to any of the following?

Acrylic Y N | Local Anesthetics Y N | Valium Y N
 Aspirin Y N | Metal Y N | Other allergies? Y N
 Latex Y N | Penicillin Y N

Are you currently taking any medications? If yes, list all:

Do you have or have you had any of the following?

Acid reflux	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive/	<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric care	<input type="checkbox"/> Y <input type="checkbox"/> N
AIDS/HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N	Abnormal bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Radiation treatment	<input type="checkbox"/> Y <input type="checkbox"/> N
Anaphylaxis	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N	Rapid weight gain/loss	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Fibromyalgia	<input type="checkbox"/> Y <input type="checkbox"/> N	Respiratory disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis, Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic/Scarlet fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial heart valves	<input type="checkbox"/> Y <input type="checkbox"/> N	Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Shingles	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial joints	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart problems/	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus troubles	<input type="checkbox"/> Y <input type="checkbox"/> N
Atopic (allergy prone)	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Surgery/Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin rash	<input type="checkbox"/> Y <input type="checkbox"/> N
Back problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N	Sleep apnea	<input type="checkbox"/> Y <input type="checkbox"/> N
Bruise easily	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Spina bifida	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
Chemical dependency	<input type="checkbox"/> Y <input type="checkbox"/> N	High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Surgical Implant	<input type="checkbox"/> Y <input type="checkbox"/> N
Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N	High cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	Swelling of feet or ankles	<input type="checkbox"/> Y <input type="checkbox"/> N
Circulatory problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Insomnia/Trouble sleeping	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Cortisone treatments	<input type="checkbox"/> Y <input type="checkbox"/> N	Jaw Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Tobacco habit	<input type="checkbox"/> Y <input type="checkbox"/> N
Cough up blood	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Tonsilitis	<input type="checkbox"/> Y <input type="checkbox"/> N
Cough, persistent	<input type="checkbox"/> Y <input type="checkbox"/> N	Leukemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcer/Colitis	<input type="checkbox"/> Y <input type="checkbox"/> N
Epilepsy or Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N	Nervous problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Venereal disease	<input type="checkbox"/> Y <input type="checkbox"/> N

Have you had any serious illness not listed above? _____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment or benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____

Date _____



5155 Stevens Creek Blvd. Suite 100
Santa Clara, CA 95051
info@crestpointedental.com
(408) 645-5551

Patient Communication Consent Form

Patient Name: _____

Voice Messages:

_____ (initial) I understand brief messages from the dental practice may be left on my home answering machine or with anyone who answers the telephone at my home unless I have provided the practice with alternate instructions for communication.

Email:

_____ (initial) Except for appointment reminders, we use secure methods to electronically communicate with our patients. Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to, or intercepted by authorized third parties. However, you may consent to receive unsecured email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify your email address.

- I prefer to receive information via the practice's secure communication methods. My email address is _____
- I consent and accept the risk of receiving information via unencrypted email. I understand I can withdraw my consent at any time. My email address is _____
- I consent to receiving appointment reminders via unencrypted email. I understand the minimum necessary information is used in these reminders. I understand I can withdraw my consent at any time. My email address is _____
- I do no consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Cellphone:

_____ (initial) I consent to the dental practice using my cell phone number to (choose one or both) to call or to text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (including area code) _____

Patient Acknowledgements and Authorizations:

_____ (initial) I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

Signature of patient _____

Date _____

Signature of Parent/ Guardian if patient is a minor _____

Date _____