CRYSTAL FALLS DENTAL
FAMILY AND COSMETIC DENTISTRY

Medical Alert for Office Use

Thank you for visiting Crystal Falls Dental. We strive to make your dental visits as pleasant and comfortable as possible. Please help us by completing this form.

Patient Information

Name_____

Address_____

Email Address_____

Employer_____ Drivers License_____

Birth Date_____ Height _____ Weight _____

Phone: Home#_____ Social Security# _____

Work# _____ May we Contact you at work? ❑ Yes ❑ No

Mobile# _____ ❑ Male ❑ Female

Emergency Contact Name & Phone number: _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security # _____DOB _____

Employer _____ Insurance Co. _____

Insurance Co. phone # _____ Group # _____

Relation to Patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signiture_____Date _____

Guardian Signature _____ Relation to Patient _____

Dental History

How did you hear about us? _____

What was the reason for today's visit? _____

What would you like to change about your smile? _____

Why did you leave your last dentist? _____

When was your last dental visit? _____

What did you like *most* about your last dentist? _____

Do your gums bleed while brushing or flossing? _____

Do you grind your teeth? _____

Do you snore or does your significant other snore? _____

Have you ever had any prolonged bleeding after an extraction or surgery? _____

Are you interested in any of the following? (Check the boxes)

Invisalign – Clear Braces	❑	More attractive smile	❑
Implants	❑	Veneers / Lumineers	❑
Bad Breath Treatment	❑	Fixing chipped teeth	❑
Gaps in teeth	❑	Missing Teeth	❑
Preventing Cavities	❑		

Medical History and Information

Conditions

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty breathing
- ❑ Ulcers
- ❑ Drug Use
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ HIV or Aids
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Hemophilia
- ❑ Hepatitis A,B, or C
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ High Blood Pressure
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ STDs
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Stroke

Are you allergic to anything, especially Penicillin, Amoxicillin or Latex? _____

Female only: Are you pregnant? If so how many weeks?_____

Please list any medications you are currently taking:

_____

_____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/ or parent or guardian to be necessary advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

Patients Signature: _____ Date: _____

Guardian Signature: _____ Date: _____