DR. C. ROSS CRAPO, INC.

WELCOME TO OUR OFFICE

Date _____ (M D Y)

PATIENT REGISTRATION ***ALL INFORMATION IS CONFIDENTIAL***

The following information is required by the dentist to assist in proper diagnosis and treatment. Please feel free to ask receptionist for help in completing this form. PLEASE PRINT.

ADULT PATIENT or PARENT (Guardian) REGISTRATION ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other_____

Are you the: ☐ PATIENT ☐ PARENT (Guardian)

Name: _____ (last) (first) (initial)

Address: _____ (street) (city) (prov./state) (postal/zip code)

Date of Birth: _____ (M D Y) Age:___ Sex:___ Marital Status_____ Home Phone: ( )_____

Cell Phone: ( )_____

Employer: _____ Work Phone: ( )_____

Care Card #: _____ Email: _____

DL#: _____

Family Physician _____ Phone: ( )_____

Address: _____ (street) (city) (prov./state) (postal/zip code)

Medical Specialist_____ Phone: ( )_____

CHILD REGISTRATION or ADULT UNDER GUARDIANSHIP

Name: _____ (last) (first) (initial)

Prefers to be called: _____ (if different than above)

Address: _____ (if different than above) (street) (city) (prov./state) (postal/zip code)

Date of Birth: _____ (Mo. Day Yr.) Age: _____ Sex: _____ Home Phone: ( )_____

School: _____ Grade: _____

Person responsible for account: ☐ Self ☐ Spouse ☐ Other If other, please complete the following:

Method of payment: Cash ☐ Cheque ☐ Credit Card ☐

Name: _____ Home Phone: ( )_____

Address: _____ (street) (city) (prov./state) (postal/zip code)

Employer: _____ Phone: ( )_____ Ext. _____

Spouse's name: _____ Occupation: _____

Employer: _____ Phone: ( )_____ Ext. _____

In case of emergency: _____ Phone: ( )_____

Closest family relative: _____ Phone: ( )_____

Is another member of your family or relative a patient at our office? _____

PRIMARY DENTAL INSURANCE

NAME OF INSURED	DATE OF BIRTH M /D /Y
EMPLOYER	
INSURANCE CARRIER	
GROUP/POLICY NUMBER	DIVISION
I.D. NUMBER OR S.I.N.	CERTIFICATE NUMBER / DEPT. NO.
COVERAGE PERCENTAGE A B C D	
LIMITS BASIC MAJOR ORTHO	
DEDUCTIBLE BASIC MAJOR	☐ PER PERSON ☐ PER FAMILY
SIGNATURE(S) REQUIRED: ☐ PATIENT ☐ INSURED ☐ EMPLOYER	
SUBMISSION: ☐ CARRIER ☐ PATIENT ☐ EMPLOYER ☐ OTHER	

SECONDARY DENTAL INSURANCE

NAME OF INSURED	DATE OF BIRTH M /D /Y
EMPLOYER	
INSURANCE CARRIER	
GROUP/POLICY NUMBER	DIVISION
I.D. NUMBER OR S.I.N.	CERTIFICATE NUMBER / DEPT. NO.
COVERAGE PERCENTAGE A B C D	
LIMITS BASIC MAJOR ORTHO	
DEDUCTIBLE BASIC MAJOR	☐ PER PERSON ☐ PER FAMILY
SIGNATURE(S) REQUIRED: ☐ PATIENT ☐ INSURED ☐ EMPLOYER	
SUBMISSION: ☐ CARRIER ☐ PATIENT ☐ EMPLOYER ☐ OTHER	

DR. C. ROSS CRAPO, INC.

MEDIC ALERT	ALLERGIES	MEDICATIONS	HEALTH COND.	PHYSICAL

MEDICAL HISTORY for | Month / Day / Year

The following information is required by the dentist to assist in proper diagnosis and treatment. **ALL INFORMATION IS CONFIDENTIAL**

	Yes	Don't Know Maybe	No
1. Have you ever had a serious illness requiring hospitalization or extensive medical care? Specify _____	[ ]	[ ]	[ ]
2. Are you presently under the care of a physician? If so, explain _____	[ ]	[ ]	[ ]
3. Have you had a medical examination in the last year?	[ ]	[ ]	[ ]
4. Do you use any prescription or non-prescription medicine regularly? Specify _____	[ ]	[ ]	[ ]
5. Do you have any allergic condition: ie. asthma, hay fever, skin rash, food allergies?	[ ]	[ ]	[ ]
6. Do any allergic reactions result in headache, shortness of breath, chest constriction, nausea? Specify _____	[ ]	[ ]	[ ]
7. Have you been hospitalized in the last 5 years?	[ ]	[ ]	[ ]
8. Have you ever experienced any unusual reaction to any of the following? (please circle) local anaesthesia (freezing), aspirin, penicillin, iodine, sulpha, barbiturates (sleeping pills), or any other medicine? If so, explain _____	[ ]	[ ]	[ ]
9. Have you been warned against taking any drug or medication?	[ ]	[ ]	[ ]

10. Do you have or have you ever had any of the following? Please check [✓]

[ ] Diabetes	[ ] Joint Replacement	[ ] Drug Addiction	[ ] Herpes / Cold Sores
[ ] Heart Attack	[ ] Mental Disorder / Anxiety	[ ] Alcohol Addiction	[ ] Arthritis / Rheumatism
[ ] Heart Murmur / Mitral Valve Prolapse	[ ] Nervous System Disorder	[ ] Hepatitis A	[ ] Sinus Trouble
[ ] Any Lung Disease	[ ] Liver Disease	[ ] Hepatitis B	[ ] Thyroid Disease
[ ] High Blood Pressure	[ ] Kidney Disease	[ ] Hepatitis C	[ ] Tuberculosis
[ ] Low Blood Pressure	[ ] Scarlet / Rheumatic Fever	[ ] Positive HIV Test	[ ] Other _____
[ ] Cancer	[ ] Malignant Hypothermia	[ ] AIDS	

	Yes	Maybe	No
11. Have you ever had any known contact with the AIDS virus?	[ ]	[ ]	[ ]
12. Has any member of your family had diabetes?	[ ]	[ ]	[ ]
13. Do you bruise easily or bleed abnormally?	[ ]	[ ]	[ ]
14. Do your ankles swell during the day?	[ ]	[ ]	[ ]
15. Have you had any weight changes recently?	[ ]	[ ]	[ ]
16. Do you have any blood disorders such as anemia (thin blood), thalassemia (major, minor)?	[ ]	[ ]	[ ]
17. Have you ever had radiation treatment or chemotherapy? If so, explain _____	[ ]	[ ]	[ ]
18. Have you ever had any injury, surgery, or x-ray therapy to your face or jaws?	[ ]	[ ]	[ ]
19. Do you have frequent severe headaches?	[ ]	[ ]	[ ]
20. Do you have frequent earaches, ear/throat infections or any hearing difficulties?	[ ]	[ ]	[ ]
21. Is your eyesight:[ ]Good [ ]Adequate [ ]Poor Do you wear contact lenses?	[ ]	[ ]	[ ]
22. Are you on a special diet?	[ ]	[ ]	[ ]
23. Have you ever fainted?	[ ]	[ ]	[ ]
24. Do you ever experience shortness of breath or chest pain when walking or climbing stairs? If so, explain _____	[ ]	[ ]	[ ]
25. Have you had any organ transplants or medical implants?	[ ]	[ ]	[ ]
26. Do you have any disease, condition, or problem that you think the doctor should know about? If so, explain _____	[ ]	[ ]	[ ]
27. Do you get nervous in the dental office?	[ ]	[ ]	[ ]
28. Is there anything about yourself that we should be made aware of? If so, explain _____	[ ]	[ ]	[ ]
29. WOMEN ONLY - Are you pregnant? If so, which month are you in? _____	[ ]	[ ]	[ ]
- Are you taking any birth control pills? _____	[ ]	[ ]	[ ]

TO AVOID COMPLICATIONS,
PLEASE NOTIFY OUR OFFICE OF ANY CHANGE IN YOUR MEDICAL CONDITION.

MEDICAL HISTORY - DENTAL HISTORY

DR. C. ROSS CRAPO, Inc.

DENTAL HISTORY for | Month / Day / Year

1. Reason for today's visit: [ ] Exam [ ] Cleaning [ ] Emergency [ ] Other _____
   Is there a dental problem you would like to have taken care of as soon as possible? _____
2. How frequently do you see your dentist? [ ] 6 Months [ ] Yearly [ ] Other _____
   Former dentist _____ Last dental visit _____
   Last cleaning _____ Last full mouth series of x-rays _____ X-rays requested _____
3. Brushing: [ ] Vigorous [ ] Light How often? _____ Type of brush? _____
4. How often do you floss your teeth? _____
5. Other cleaning aids used: [ ] Floss [ ] Stimudents [ ] Toothpick [ ] Other _____
6. Are any of your teeth sensitive to: [ ] Cold [ ] Sweets [ ] Heat [ ] Other _____
7. Do your gums bleed when: [ ] Brushing [ ] Flossing [ ] Spontaneously
8. Please rate your sugar intake: [ ] High [ ] Medium [ ] Low

9. Have you ever had or do you now have any of the following? Please check [✓]

[ ] Bridges	[ ] Lost fillings	[ ] Bite appliance/night guard	[ ] Gum treatments
[ ] Partial dentures	[ ] Extractions	[ ] Swelling or pain in your	[ ] Gag easily
[ ] Full dentures	[ ] Loose teeth	mouth or jaws	[ ] Difficulty opening
[ ] Root canal fillings	[ ] Orthodontic treatment	[ ] Injuries to your face or jaws	or closing your jaw
[ ] Dental implants	[ ] Bite adjustment	[ ] Surgery in your mouth	

	Yes	Don't Know Maybe	No
10. Do you chew on only one side of your mouth? If so, why? _____	[ ]	[ ]	[ ]
11. Does any part of your mouth hurt when clenched? _____	[ ]	[ ]	[ ]
12. Does your jaw crack or pop when opened widely? _____	[ ]	[ ]	[ ]
13. Do you have any pain in your ears? _____	[ ]	[ ]	[ ]
14. Have you experienced any growth or sore spots in your mouth? If so, where? _____	[ ]	[ ]	[ ]
15. Do you?- grind or clench your teeth during the day or night? _____	[ ]	[ ]	[ ]
- mouth breathe while awake or asleep? _____	[ ]	[ ]	[ ]
- bite your lips or cheeks regularly? _____	[ ]	[ ]	[ ]
-hold any foreign objects with your teeth? (ie. pipe, pencils, nails) _____	[ ]	[ ]	[ ]

- smoke? [ ] Cigarettes [ ] Cigars [ ] Pipe [ ] Marijuana [ ] Other

16. Check (✓) any of the following you have experienced

[ ] Orthodontics (braces)	[ ] Repairing chipped teeth	[ ] Improved gum health
[ ] Bonding (straightening)	[ ] Bleaching (whitening teeth)	[ ] Improving your bite
[ ] Closing spaces between teeth	[ ] Crowns (caps)	[ ] Improving breath odor
[ ] Replacing missing teeth	[ ] Sports mouth guard	[ ] Improving your smile

17. Would you rate your current dental health as: [ ] Excellent [ ] Good [ ] Fair [ ] Poor

INFORMED CONSENT / GENERAL RELEASE

I, the undersigned, state that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical/Dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as may be necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services provided to me or my dependents.

Patient (Parent, Guardian) Signature: _____

If parent, guardian*, please print name _____ Date m/____ d/____ y/ ____

**Guardian of Child or Guardian of Adult under Guardianship*