



# CRESTA

DENTAL IMPLANTS

## WELCOME TO OUR PRACTICE

DATE: \_\_\_\_\_

### Patient Information

First: \_\_\_\_\_ Middle \_\_\_\_\_ Last: \_\_\_\_\_

Street: \_\_\_\_\_ Apt. # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Patient Social Security #: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_ Sex: M F

\_\_\_ Married \_\_\_ Single \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

If Student, name of School/College: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

How did you hear about us?

Insurance Provider  Television  Radio  Mailing  Social Media  Online Review  
 Internet  Community Event  Other  Referral \_\_\_\_\_ (Patient Name)

**If the person responsible for this patient's account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information".**

Name of responsible party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: M F Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Single Married Widowed Separated Divorced SS#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Insurance Information

#### Primary Dental Insurance

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_ State: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Group #: \_\_\_\_\_ Member ID #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

#### Secondary Dental Insurance

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_ State: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Group #: \_\_\_\_\_ Member ID #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

**HEALTH HISTORY**

Answers to the following questions are for our records only and will be considered confidential.

Place a mark, yes or no, to indicate if you have had any of the following:

Heart Disease or Attack	Yes	No	Shortness of Breath	Yes	No	Alcoholism	Yes	No
Angina Pectoris	Yes	No	Ulcers	Yes	No	Herpes	Yes	No
Heart Problems	Yes	No	Intellectual Disability	Yes	No	Glaucoma	Yes	No
Liver Disease	Yes	No	Emphysema	Yes	No	*Steroid Treatment	Yes	No
High Blood Pressure	Yes	No	Fainting or Dizzy Spells	Yes	No	Arthritis	Yes	No
*Heart Murmur	Yes	No	Epilepsy or Seizures	Yes	No	Birth Defects	Yes	No
*Rheumatic Fever	Yes	No	Persistent Cough	Yes	No	HIV Positive, ARC, AIDS	Yes	No
Psychiatric Treatment	Yes	No	Tuberculosis (TB)	Yes	No	Hay Fever	Yes	No
Sickle Cell Disease	Yes	No	Asthma	Yes	No	Use of Tobacco Products	Yes	No
Sinus Trouble	Yes	No	*Congenital Heart Problems	Yes	No	Bruise Easily	Yes	No
*Artificial Joints	Yes	No	Hepatitis A (Infectious)	Yes	No	Jaundice	Yes	No
Thyroid Disease	Yes	No	Hepatitis B (Serum)	Yes	No	Kidney Trouble	Yes	No
Anemia	Yes	No	Hepatitis C or Other	Yes	No	Human Papilloma Virus/HPV	Yes	No
Blood Transfusion	Yes	No	Heart Pacemaker	Yes	No	Hemophilia	Yes	No
*Any Type of Transplant	Yes	No	Stroke	Yes	No	Diabetes ___Type I ___Type II	Yes	No
*Mitral Valve Prolapse	Yes	No	Drug Addiction	Yes	No	Chemotherapy/Radiation	Yes	No
Hives or Skin Rash	Yes	No	Cold Sores	Yes	No	Cancer, type: _____	Yes	No
Scarlet Fever	Yes	No	COPD <small>(Chronic Obstructive Pulmonary Disorder)</small>	Yes	No	MRSA	Yes	No

\*Antibiotic pre-medication may be required prior to your appointment.

**ALLERGIES**

Aspirin                      Local Anesthetic                      None  
 Barbituates                Penicillin  
 Codeine                     Sulfa  
 Iodine                        Metals  
 Latex                         Other: \_\_\_\_\_

**MEDICATIONS**

Please list medications you are currently taking:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Pharmacy: \_\_\_\_\_

Do you have existing dentures      Yes      No      How old is denture \_\_\_\_\_      Upper/Lower  
 Do you have existing partials      Yes      No      How old is partial \_\_\_\_\_      Upper/Lower

1. Have you or any member of your family been seen by us before?      Yes      No  
 If yes, which family member(s)? \_\_\_\_\_
2. Date of last physical examination: \_\_\_\_\_      Physician's name: \_\_\_\_\_
3. Previous dentist's name: \_\_\_\_\_      Date of last dental x-rays: \_\_\_\_\_
4. Are you having pain or discomfort at this time?      Yes      No
5. Do you clench or grind your teeth?      Yes      No
6. Do you have any sores, lumps or growths in or near your mouth?      Yes      No
7. Have you ever had any excessive bleeding requiring special treatment?      Yes      No
8. Have you ever needed to see a periodontist?      Yes      No
9. Is there anything you would like to change about the way your smile looks?       straighter       whiter
10. Do you currently have any of the following?       swelling       bleeding gums       loose teeth       bad breath
11. Have you experienced any reactions to treatment in your previous visits to the Dentist?      Yes      No  
 If yes, please explain: \_\_\_\_\_
12. Is there anything related to your medical or dental history that you have not indicated above?      Yes      No  
 If yes, please explain: \_\_\_\_\_

WOMEN: Are you pregnant now?      Yes      No      If yes, what is your due date? \_\_\_\_\_  
 Are you currently breast feeding?      Yes      No  
 Are you taking oral contraceptives?      Yes      No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

**X** \_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
 Signature of Patient or Parent/Guardian      Print Name      Date

**X** \_\_\_\_\_      \_\_\_\_\_  
 Doctor Signature      Date