Health History / Personal Information

Male ❑ Female ❑ Child ❑ Single ❑ Married ❑

PATIENT'S NAME ________________ DATE OF BIRTH ________________

RESPONSIBLE PARTY Self ❑ Parent ❑ Guardian ❑

NAME (OF RESPONSIBLE PARTY)

ADDRESS

CITY / STATE ________________ ZIP CODE ________________

HOME PHONE ________________ CELL PHONE ________________

EMAIL ADDRESS (FOR APPOINTMENT REMINDERS ONLY)

SOCIAL SECURITY NUMBER ________________ DATE OF BIRTH ________________

EMERGENCY CONTACT ________________ EMERGENCY PHONE ________________

OCCUPATION ________________ WORK PHONE ________________

REFERRED BY

PRIMARY INSURANCE (Please notify us if you have a secondary insurance.)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT

DENTAL INSURANCE COMPANY

GROUP NUMBER

SUBSCRIBER NAME

SUBSCRIBER EMPLOYER

SUBSCRIBER SOCIAL SECURITY #

SUBSCRIBER ID #

SUBSCRIBER DATE OF BIRTH

NAME OF SPOUSE / GUARDIAN

EMPLOYER OF SPOUSE / GUARDIAN

Health History / Personal Information

crisdental

Your dental and medical history are important. Many things have a direct bearing on your dental health.
The information you provide is confidential and will not be released without your permission.

1. Name, phone number, and address of your Physician

2. Are you taking any prescription / over-the-counter drug(s)? **YES** ❑ **NO** ❑

If yes, please list each one

3. Have you ever been treated for any of the following:

Condition	YES	NO	Condition	YES	NO
Anemia	**YES** ❑	**NO** ❑	Heart Attack/Failure	**YES** ❑	**NO** ❑
Angina	**YES** ❑	**NO** ❑	Heart Murmur	**YES** ❑	**NO** ❑
Arthritis/Gout	**YES** ❑	**NO** ❑	Heart Pacemaker	**YES** ❑	**NO** ❑
Artificial Heart Values	**YES** ❑	**NO** ❑	Hemophilia	**YES** ❑	**NO** ❑
Artificial Joints	**YES** ❑	**NO** ❑	Hepatitis (A,B, or C)	**YES** ❑	**NO** ❑
Asthma	**YES** ❑	**NO** ❑	High Blood Pressure	**YES** ❑	**NO** ❑
Blood Disease	**YES** ❑	**NO** ❑	Kidney Problems	**YES** ❑	**NO** ❑
Cancer	**YES** ❑	**NO** ❑	Liver Disease	**YES** ❑	**NO** ❑
Congestive Heart Disorder	**YES** ❑	**NO** ❑	Stroke	**YES** ❑	**NO** ❑
Diabetes	**YES** ❑	**NO** ❑	Tuberculosis	**YES** ❑	**NO** ❑
Drug Addiction	**YES** ❑	**NO** ❑	Lung Disease	**YES** ❑	**NO** ❑
Epilepsy or Seizures	**YES** ❑	**NO** ❑	Thyroid Disease	**YES** ❑	**NO** ❑
Glaucoma	**YES** ❑	**NO** ❑	Ulcers	**YES** ❑	**NO** ❑

4. Are you currently taking or have you ever taken bisphosphonates, either orally or by I.V. ? (Examples: Fosamax, Boniva)
YES ❑ **NO** ❑ **ORALLY** ❑ **I.V.** ❑

5. Are you allergic to any of the following: **Penicillin** ❑ **Aspirin** ❑ **Codeine** ❑ **Latex** ❑ **Dental Anesthetics** ❑

6. Please list any other drug(s) that you are allergic to: __________

7. Other physical conditions we should be aware of: __________

8. Women only: Are you pregnant or think you might be? **YES** ❑ **NO** ❑ Are you nursing? **YES** ❑ **NO** ❑

For Electronic Submission: I do hereby acknowledge that this transaction is being conducted by electronic means and by typing my name herein below or transmitting this document to Crisdental, I am subscribing to this agreement and thereby providing my electronic signature. By typing my name in the space below or by the act of transmitting this document to Crisdental, I intend to be bound by the terms and conditions of the doctor-patient agreement herein and the terms and conditions therein are in full force and effect and legally enforceable against me.

I understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence in accordance with HIPPA regulations and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment.

Patient's Signature or Legal Guardian (Type in name if submitting electronically) Date

Health Info and Payment Policy

crisdental

Crisdental, PC may disclose health information such as, but not limited to, appointment time(s) and treatment, to family member(s), friend(s) or to whomever you request. But only if you agree that we may do so. Please list the individual(s) below who you authorize us to share your health information with.

(Name)	(Relationship)
(Name)	(Relationship)

Patient's Signature or Legal Guardian
(Type in name if submitting electronically.)

Date

Payment Policy

We will gladly process your insurance claim(s) for you and estimate your portion that is not covered by insurance. Any amount that is not covered by insurance is due at the time of service. If you do no have insurance full payment is due at time of service. Our estimates are subject to final approval by your insurance company and could change even after treatment has been completed. Cash paying discounts, if applicable, only apply when payment is made the same day as service. Any payment made after day of service will not receive any discount. By signing at the bottom you agree to the above and to the following:

1. **Cash, Check, Visa, Master Card, and are acceptable methods of payment.**
2. **A $50.00 No-Show fee will be charged for any appointment canceled without at least 24 hours notice.**
3. **A $25.00 charge will be billed to patient for any check returned to bank for any reason.**
4. **Finance charge(s) of up to 18% APR will be applied on all balances over 90 days past due.**

I have been offered a copy of Receipt of Privacy Practice

Patient's Signature or Legal Guardian (Type in name if submitting electronically.)	Print Name	Date
Parent/Legal Guardian Signature (Type in name if submitting electronically.)	Print Name	Date

For Electronic Submission: I do hereby acknowledge that this transaction is being conducted by electronic means and by typing my name herein below or transmitting this document to Crisdental, I am subscribing to this agreement and thereby providing my electronic signature. By typing my name in the space below or by the act of transmitting this document to Crisdental, I intend to be bound by the terms and conditions of the doctor-patient agreement herein and the terms and conditions therein are in full force and effect and legally enforceable against me.

Authorization to Release Dental Records

I hereby authorize and request Dr. ______________________________ to release all x-rays taken within the last 5 years and any pertinent chart notes to:

☐ **Central Point**
826 S Front St
Central Point, OR 97502
crisdentalcentralpoint@gmail.com

☐ **Eagle Point**
217 W Main St
Eagle Point, OR 97524
eaglepoint@crisdental.com

☐ **Eugene**
2377 Oakmont Way Suite B
Eugene, OR 97401
eugene@crisdental.com

☐ **Newberg**
701 Foothills Drive
Newberg, OR 97132
newberg@crisdental.com

☐ **Roseburg**
2530 Medical Park Dr.
Roseburg, OR 97471
adbeautiful.smiles@live.com

☐ **Salem**
1355 Edgewater St
Salem, OR. 97304
salem@crisdental.com

☐ **Springfield**
5892 Main St. Suite 4
Springfield, OR. 97478
crisdentalthurston@live.com

☐ **Lincoln City**
2604 NW Highway 101
Lincoln City, OR. 97367
lincolncity@crisdental.com

☐ **Grants Pass**
1228 NE 7th St.
Grants Pass, OR. 97526
grantspass@crisdental.com

____
Patient Name (please print)

____
Patient Date of Birth

____
Patient Signature (or legal guardian)

____
Date

Additional Family Members:

____

____

print form ▶ submit form via email ▶