Today's Date:

Patient Information:

Name (First MI Last):	I prefer to go by:	Primary Phone:	
Mailing Address:	City:	State:	Zip:
Date of Birth:	Sex: M / F	Age:	Marital Status: Single Married Separated Divorced Widowed
Social Security Number:	Emergency Contact:	Phone (including area code):	
Employer:	Occupation:		

Person Responsible for Account:

Name (First MI Last):		Primary Phone:	
Mailing Address:	City:	State:	Zip:
Date of Birth:	Sex: M / F	Marital Status: Single Married Separated Divorced Widowed	
Social Security Number:	E-mail:		
Employer:	Occupation:		
Whom may we thank for referring you?			

Primary Insurance:

Primary Insurance Company:	Insured Name (First MI Last):
Employer:	Insured SSN or Member ID:
Date of Birth:	Relationship to patient:

Secondary Insurance:

Primary Insurance Company:	Insured Name (First MI Last):
Employer:	Insured SSN or Member ID:
Date of Birth:	Relationship to patient:

Authorization

I authorize my insurance company to pay Crystal Valley Family Dentistry P.C. 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 of benefits. I understand that payment is due in full at the time of treatment unless prior arrangements have been approved. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that a 1.5% monthly late fee may be charged if payments are not received within 30 days of the billing date. If after 90 days no payment has been received, I understand that a collection service may be used and agree to pay all collections cost, including, but not limited to responsible attorney fees.

_____ _____

Signature Date

Effective April 1, 2022:

Any appointment missed without a 24-hour notice will be subject to a $50 cancellation fee added to your account. In addition, a deposit to schedule remaining treatment may be required.

Initials _____

Patient Name:	Date:

Check any of the following which you have had or have at present:

- □ Heart conditions
- □ Heart attack or stroke
- □ Heart murmur
- □ Chest pains (angina)
- □ Heart surgery
- □ Artificial heart valve
- □ Heart Pacemaker
- □ High blood pressure
- □ Rheumatic fever
- □ Anemia or Hemophilia
- □ Bruise easily
- □ Shortness of breath
- □ Swelling of ankles
- □ Artificial joint
- □ Lung disease
- □ Emphysema
- □ Tuberculosis (TB)
- □ Asthma or hay fever
- □ Skin rashes or hives
- □ Kidney trouble
- □ Diabetes
- □ Sickle cell disease
- □ Liver disease
- □ Hepatitis B
- □ Hepatitis C
- □ Yellow jaundice
- □ Blood transfusion
- □ Thyroid disease
- □ Cortisone medicine
- □ Glaucoma
- □ Arthritis or rheumatism
- □ Pain in joints
- □ Fainting or dizzy spells
- □ Alcoholism
- □ Drug addiction
- □ Cancer or tumor
- □ Radiation therapy
- □ Chemotherapy
- □ HIV positive/AIDS
- □ Venereal disease
- □ Genital herpes
- □ Cold sores
- □ Epilepsy or seizures
- □ Psychiatric treatment

Other:

_____

Your present health: Good Fair Poor	Are you having discomfort at this time? Yes No
Physician:	Phone Number:

Do you have any diseases, conditions or problems not listed above?	No	Yes
If yes, please explain:		
Are you presently taking any prescription or over-the-counter medications or drugs?	No	Yes
If yes, please list:		
Are you allergic to any medicine, latex, nickel or other substances?	No	Yes
If yes, please list:		
Are you now or have you been under the care of a medical doctor during the last two years?	No	Yes
Have you ever been hospitalized or had surgery?	No	Yes

Have you ever had prolonged or unusual bleeding?	No	Yes
Have you ever had complications or illness following dental treatment?	No	Yes
Have you ever had an injury or trauma to your face or jaw?	No	Yes
Do you smoke or use smokeless tobacco?	No	Yes
Are you nervous or concerned about having dental work done?	No	Yes
Women:		
Are you pregnant?	No	Yes
If so, due date:		

Comments:

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct.

_____ _____

Signature Date

PERSONAL MEDICAL HISTORY