Crossroads Dental Care 221 Flamingo Road, Mill Valley, CA 94941 www.tandentalmarin.com

WELCOME

PATIENT INFORMATION

Date: _____

Patient Name: _____ __ M __F __ Married __ Single __ Other
Last First Middle Gender Marital Status

Social Security #: _____ Birth date: _____ E-mail Address:_____

Home Address: _____City: _____ Zip Code: _____

Telephone: (H): _____ (W): _____ (ext): _____ (C): _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ Zip Code: _____

Spouse's Name: _____ Birth date: _____ Social Security #: _____

Whom may we thank for referring you? _____

Emergency Contact: _____ Phone: _____

Who is responsible for this account? Relationship: ___Self___ Spouse___ Parent or Guardian___ Other

Responsible Party's Name: _____ SSN: _____ Birth date: _____

Street Address (If Different): _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Name of Subscriber: _____ Relationship to Patient: __ Self __ Spouse __ Child __ Other
Last First MI

Birth date: _____ SSN: _____ Is the Subscriber a Patient?: __Y __N

Subscriber Address: _____ City/Zip Code: _____

Subscriber's Employer: _____ Group No.: _____

Member ID #: _____ Insurance Phone: _____

Secondary Insurance: _____

Name of Subscriber: _____ Relationship to Patient: __ Self __ Spouse __ Child __ Other
Last First MI

Birth date: _____ SSN: _____ Is the Subscriber a Patient?: __Y __N

Subscriber Address: _____ City/Zip Code: _____

Subscriber's Employer: _____ Group No.: _____

Member ID #: _____ Insurance Phone: _____

Patient Name:_____

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Medical & Dental Information

Name of Physician: _____ Phone: _____ Last Exam: _____

Are you undergoing medical treatment now? __ Yes __ No If "yes," please explain: _____
Have you been admitted to a hospital or needed emergency care in the past two years? __ Yes __ No
If yes, please explain: _____
Are you taking any medications, including non-prescription or herbal medicine? __ Yes __ No
If yes, please list ***ALL*** medications you are taking: _____

_____

Have you ever taken prescription diet drugs (ie. Phen-Fen, Redux)? __ Yes __ No
Are you taking or have ever taken drugs due to bone density or osteoporosis? Bisphosphonates (ie. Fosamax, Bovina, etc…)? __ Yes __ No
If yes, how was is taken? __ IV __ Tablets How long did you take the medication? _____

Have you ever had an ***ALLERGIC*** reaction to any of the following?

If yes, what symptoms did you have: _____
_____
_____

Please list any other allergies: _____

Yes No
___ ___ Local Anesthetics
___ ___ Penicillin
___ ___ Sulfa Drugs
___ ___ Metals (Nickel, Mercury, etc…)
___ ___ Latex/Rubber
___ ___ Codeine

Do you have or have you had any of the following?

Yes No	Yes No	Yes No	Yes No
__ __ AIDS/HIV	__ __ Epilepsy/Seizures	__ __ Heart Murmur	__ __ Pacemaker/Shunt
__ __ Anemia	__ __ Excessive Bleeding	__ __ Hearing Problems	__ __ Radiation Therapy
__ __ Angina	__ __ Fainting Spells	__ __ Hepatitis, Type _____	__ __ Respiratory Problems
__ __ Arthritis	__ __ Glaucoma	__ __ High Blood Pressure	__ __ Rheumatic Fever
__ __ Asthma	__ __ Growths/Tumors	__ __ Jaundice	__ __ Sexually Transmitted Disease
__ __ Cancer	__ __ Hay Fever/Allergies	__ __ Joint Replacement/Implants	__ __ Smoke/Use Tobacco
__ __ Chest Pain	__ __ Head Injuries/Trauma	__ __ Kidney Disease	__ __ Stroke
__ __ Diabetes	__ __ Heart Attack	__ __ Low Blood Pressure	__ __ Thyroid Problems
__ __ Dizziness	__ __ Heart Disease	__ __ Mental/Nervous Disorder	__ __ TMJ Problems (TMJD)
__ __ Emphysema	__ __ Mitral Valve Prolapse	__ __ Tuberculosis	__ __ Artificial Heart Valve
__ __ Eating Disorders/Anorexia/Bulimia Nervosa		__ __ Stomach Problems/Ulcers/GERD	__ __ Herpes/Cold sores
__ __ Recreational Drug Use			

Other Medical Conditions Not Listed Above: _____
Women Only: Are you pregnant? __ Yes __ No Due Date: _____ Are you nursing? __ Yes __ No

Reason for today's visit: _____
Previous Dentist: _____ City: _____State:_____ Phone: _____
Date of your last dental visit?_____What was done then? _____
Did you make regular visits to the dentist before then? __Yes __ No How frequently? _____
Have you ever had any complications following dental treatment? __ Yes __ No
If yes, please explain: _____

Do you wear dentures or partial dentures? __Yes__No
(If yes) Year constructed?_____

Do you clench or grind your teeth during the day or night? __Yes__ No

Does your jaw click when you open or close? __Yes__ No

Have you had gum disease or gum surgery? __Yes__ No

Are you satisfied with the appearance of your teeth?__Yes__No

Do you awaken and notice tension in your jaw muscles? __ Yes__No

Do you have difficulty opening your mouth widely? __Yes__ No

Is your mouth or teeth sensitive to:
__Bite pressure __Cold__Heat __Sweets

Have you had orthodontic treatment? __Yes__ No

Have you ever had pain in you jaw joint or face(in and about your ears)? __Yes__ No

Do your gums bleed when brushing? __Yes__ No

Does food catch between your teeth? __Yes__ No

I acknowledge that to the best of my knowledge, all of the above information is correct and true. I hereby grant authority to the dentist(s) in charge of my/the patient's care to administer such anesthetics, analgesics, sedatives and nitrous oxide sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of myself/this patient. I have been informed of possible risks and complications of the procedures, medications and/or drugs.

Signature:_____ Date: _____ Relationship to Patient: _____

Doctor Signature: _____ Date: _____