Crawford Dental Clinic

Serving Taber and area for 40 years

Personal Information

Name: _____

Date of Birth: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Insurance Information

<u>Primary Plan</u>

Policy Holder: _____

Employer: _____

Insurance Company: _____

Plan Group #: _____

Certificate #: _____

<u>Secondary Plan</u>

Policy Holder: _____

Employer: _____

Insurance Company: _____

Plan Group #: _____

Certificate #: _____

Dental History

- Do you have any dental problems or concerns presently? _____
- If you have been to a different dental office within the past year, please record the date and name of the clinic.

  _____
- Do you have sensitivity to hot/cold, sweets or pressure? ☐ Yes ☐ No
- Do your gums bleed when you brush your teeth? ☐ Yes ☐ No
- Do you have abnormal bleeding associated with prior extractions? ☐ Yes ☐ No
- Do you grind/clench your teeth? ☐ Yes ☐ No
- Do you have any cracking or clicking of your jaw? ☐ Yes ☐ No
- Do you wear complete or partial dentures? ☐ Yes ☐ No

Medical History

Medical Doctor's name: _____

Do you have any of the following?

☐ Asthma
☐ Blood Thinners
☐ Cancer
☐ Congenital Heart Lesions
☐ Chronic Cough
☐ Chronic Diarrhea
☐ Diabetes
☐ Emotional Problems
☐ Epilepsy
☐ Gastrointestinal Problems
☐ Head or Face Injury
☐ Hearing Disorder
☐ Heart Disease
☐ Heart Attack
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ Hormonal Disorder
☐ Kidney Problems
☐ Low Blood Pressure
☐ Rheumatic Fever
☐ Stroke
☐ Thyroid Condition
☐ Tobacco Use
☐ Tumors/Growths
☐ Undiagnosed Skin Rash

Allergies?

☐ Aspirin
☐ Codeine
☐ Dental Anesthetics
☐ Erythromycin
☐ Jewelry
☐ Latex
☐ Metals
☐ Penicillin
☐ Sulpha
☐ Tetracycline

Women:

Are you pregnant?
☐ Yes ☐ No
If so, # of weeks?
_____
Are you nursing?
☐ Yes ☐ No

Other: _____

- Are you taking any medications? (If so, please list) _____

  _____
- Have you been exposed to the AIDS virus? ☐ Yes ☐ No
- Have you had any joint replacement(s) or heart surgery? ☐ Yes ☐ No
  (If so, please list)
- Do you have a history of fainting? ☐ Yes ☐ No

This is to inform you that our office uses tooth conserving white fillings wherever possible
Some dental plans DO NOT cover the full cost of white fillings

This is to certify that I, the undersigned, consent to the performing of the dental and oral procedures agreed to be necessary or advisable, including the use of general or local anesthetic as indicated and I will assume responsibility for fees associated with those procedures. In the presence of insurance, I authorize the handling of my insurance and exchange of information whether electronically or manually by Crawford Dental Clinic.

Signature: _____ Date: _____