CROSSROADS DENTAL
AMY FARMER, DDS

Welcome to our office!

Please take a moment to share with us your information…

Name: _____ Preferred name or nickname: _____

Home address/City/State/Zip Code: _____

_____

Home telephone number: _____ Work phone: _____

Cell Phone: _____ Email address: _____

How do you prefer to be contacted? Text _____ Phone _____ Email _____

Date of birth: _____ Social security number: _____

Your occupation: _____ Marital Status: _____

If you are a student, please list the school you are attending: _____

Whom may we thank for referring you to our practice? _____

Insurance information…

Do you have dental insurance? _____ Primary card holder's name: _____

Primary card holder's employer: _____ Insurance company name: _____

Insurance company phone number: _____ Insurance company group number: _____

Primary card holder's date of birth: _____ Primary card holder's social: _____

Please list the member or subscriber ID number if one is provided: _____

Your relationship to the card holder: Self Spouse Child

Emergency contact information…

Whom may we notify in case of an emergency? _____

Best contact number: _____

Address: _____

CROSSROADS DENTAL
AMY FARMER, DDS

Medical History

Please answer the following questions so that we may provide optimum care for you…

Are you currently under the care of a medical doctor? _____

If so, please provide the doctor's name and reason for care: _____

_____

Are you currently taking any prescription drugs? Please list: _____

_____

Do you have any allergies? Please list: _____

Are you pregnant or suspect you may be pregnant? _____ Do you take birth control? _____

Have you had any major surgeries in the last five years? _____ Please list date: _____

Do you have pins, plates, screws, or artificial joints? _____

Have you ever taken Fen Phen or Redux? _____ If so, did you have a cardio exam? _____

Do you use more than two pillows to sleep at night? _____ Do you wake up with shortness of breath? _____

Have you lost or gained more than ten pounds in the last year? _____ Are you on a special diet? _____

Have you ever been informed of a heart murmur, condition, or had heart surgery? Please explain in detail: _____

_____

Have you ever bled excessively? _____ Have you ever had complications with anesthesia? _____

Please circle any of the following and provide a date if you have had or currently have:

High/low blood pressure:	Rheumatic Fever:	Glaucoma (wide or narrow?):	Angina Pectoris:	
Tuberculosis:	Chemotherapy:	Mitrovalve Prolapse:	Liver Disease:	HIV:
AIDS:	Hepatitis A, B, or C:	Chest pain:	Yellow Jaundice:	Anemia:
Blood Transfusion:	Hemophilia:	Sickle Cell Disease:	Kidney Trouble:	Stroke:
Congenital Heart Lesions:	Scarlet Fever:	Hay Fever:	Narcotic addiction:	Hives:
Sinus Trouble:	Asthma:	Emphysema:	Arthritis:	
Rheumatism:	Cortisone Meds:	Psychiatric Treatment:	Drug Addictions:	Epilepsy:
Fainting:	Nervousness:	Eating Disorder:	Diabetes:	
Thyroid Disease:	Ulcers: Cold Sores:	X-ray or Cobalt Treatment:	bisphosphonates (osteoporosis):	

Is there anything that has not been covered on this form that you would like to share with us regarding your overall dental history? _____

The information I have give today is true and correct to the best of my knowledge. I will inform the doctor/assistant/hygienist if there is any change in my medical or dental status.

_____

Guest Signature: Date: Doctor's Signature: Date:

CROSSROADS DENTAL
AMY FARMER, DDS

Dental History

Please answer the following questions so that we may provide optimum care for you…

Reason for today's visit: _____

How long has it been since you last dental visit? _____ Were dental x-rays taken? _____

Previous Dentist's name: _____ Previous Dentist's phone number: _____

Was there any recommended dental treatment not completed? _____

Do you feel nervous about having treatment? Yes No

Have you ever had an unpleasant experience at a dental office? Yes No

Are your teeth sensitive to: Heat Cold Biting Pressure Sweets

Does your jaw pop or click? Yes No

Do you clench or grind your teeth? Yes No

Do you have frequent head, neck, or shoulder aches? Yes No

Have you ever had braces or other orthodontic treatment? Yes No

Does food constantly get stuck between your teeth? Yes No

Do you brush and floss daily? Yes No

Do your gums ever bleed when you brush or floss? Yes No

Is there ever an unpleasant taste or odor in your mouth? Yes No

Do you smoke or use tobacco? Yes No Have you ever smoked or used tobacco? Yes No

In general, how do you feel about your overall dental health? _____

Are you dissatisfied with the way your teeth look? If so, please explain (i.e. shape, color, and aesthetics):

_____

_____

Is there anything that has not been covered on this form that you would like to share with us regarding your overall dental history? _____

The information I have give today is true and correct to the best of my knowledge. I will inform the doctor/assistant/hygienist if there is any change in my medical or dental status.

_____

Guest Signature: Date: Doctor's Signature: Date: