Crossbridge DENTAL

Welcome to Crossbridge Dental. We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

REGISTRATION FORM

Name (First) _____ (Middle Initial) _____ (Last) _____
Address_____
City_____ State_____ Zip_____
Social Security #_____ Birthday _____/_____/_____
Telephone (Home) _____ (Work) _____ (Cell) _____
Email Address_____
How would you prefer to have appointments confirmed? Voicemail, Text Message, or Email
Whom may we thank for referring you to Crossbridge Dental? _____
Employer_____ Occupation_____
Personal to notify in an emergency_____ Phone_____
Pharmacy you normally use_____

HEALTH QUESTIONS

Is your general health good? ❑ Yes ❑No
Do you have any allergies to any food, medication or metals? ❑ Yes ❑ No
If so, which ones? _____
Please CHECK those medical conditions for which you are receiving medical care or for which you have been diagnosed or received medical treatment in the past.

❑Antidepressant Medications
❑Artificial Heart Valve
❑Artificial Joint Replacement
❑Asthma
❑Bleeding Problems
❑Blood Pressure
❑Cancer Type: _____
❑Diabetes
❑Epilepsy
❑Heart Murmur
❑Heart Attack
❑Hemophilia
❑Hepatitis A, B, C, D
❑HIV or AIDS
❑Mitral Valve Prolapse
❑Radiation Therapy
❑Rheumatic Fever
❑Rheumatoid Arthritis
❑Other_____

❑Females: Are you pregnant or breastfeeding? If Pregnant, how may weeks? _____

Is there any other information about your health which should be known? ❑Yes ❑No
Please list all current medications_____
_____
Do your medications cause dry mouth? ❑Yes ❑No
Physician Name_____ Date of last Visit_____

DENTAL INSURANCE INFORMATION

Insured is: ❑ Self ❑ Spouse ❑ Dependent

Employee's Name_____ Employee's Social Security # _____

Insurance Company_____ Group #_____

Subscriber ID_____ Employee's Date of Birth_____

Employer_____ Employer's Address_____

Is insured a full time student? ❑Yes ❑NO

Are you covered with a second dental insurance company? ❑Yes ❑No

If yes, Employee's Name_____ Employee's Social Security #_____

Insurance Company_____ Group#_____

Subscriber ID_____ Employee's Date of Birth_____

Employer_____ Employer's Address_____

PLEASE READ, SIGN, AND DTE THE SECTION BELOW

I give my permission for treatment to be performed for myself or my dependent child at this visit and at future visits. I hereby authorize any Provider, insurer, or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim of the Plan administrator or its authorized agent for the purpose of determining benefits payable.

I understand that I am financially responsible for care provided and that insurance is considered a method of reimbursement but is not a substitution for payment. I authorize my signature to be "on file" for the processing of dental claims on my or my family's behalf and authorize benefits to be paid directly to Crossbridge Dental, PC. I understand that deductibles, co-payments and non-covered services are my responsibility to pay at the time of service unless other arrangements have been made.

Our office only uses the best materials so that you maintain optimal oral health. This office does not use amalgam (silver fillings). Your insurance may only cover amalgam fillings on back teeth. If this is their policy then you will be responsible for the difference in price and coverage between tooth colored and amalgam fillings. When getting crowns we only use the best material for the tooth that is involved. Your insurance may only reimburse you for a lesser quality material. If this is the case I understand that I will be responsible for the difference in fees and payments.

A 2.0% finance charge will be added to balances over 45 days old and any balance over 90 days old may be sent to a collection agency unless prior payment arrangements have been made. Any collection fees incurred by this office in attempt to obtain payment, or bank fees for a returned check, or fees for an appointment missed or broken with less than 24 hour notice will be my responsibility.

X_____ Date_____/_____/_____

Patient or Parent/Guardian

The highest compliment our patients can give us is the referral of their friends and family.

Thank you for your trust!

DENTAL HISTORY

Reason for today's visit_____
Previous Dentist Name_____ Address_____
Date of last cleaning_____ Last Dental Visit_____ Last Full Mouth X-rays_____
Rate your smile from 1-10_____ what would you change _____
Does dental treatment make you nervous? ❑Yes ❑No
Are there old fillings or dental work that you don't like? ❑Yes ❑No
If not, explain? _____
How often do you brush? _____ Floss_____ Do you use a soft toothbrush? _____

Are any of your teeth sensitive to:
❑Hot ❑Cold ❑Chewing ❑Biting ❑ Sweets

Do you notice:
Any mouth odor or bad breath? ❑ Yes ❑ No
Cold sores, blisters or any other oral lesions? ? ❑ Yes ❑ No
Gums Bleeding or hurt? ❑ Yes ❑ No
Any loose teeth or a change in bite? ❑ Yes ❑ No

Do you:
Clench or grind your teeth while awake?
Clench or grind your teeth while asleep? ❑ Yes ❑ No
Bite your lips or cheeks regularly? ❑ Yes ❑ No
Hold foreign objects with your teeth? ❑ Yes ❑ No
(pencils, pipe, pins, nails, fingernails)
Mouth breathe while awake or asleep? ❑ Yes ❑ No
Have tired jaws, especially in the morning? ❑ Yes ❑ No
Smoke or use chewing tobacco? ❑ Yes ❑ No
If yes, how many cigarettes a day?_____ For how many years?_____
How often do you chew tobacco?_____ Where do you place it?_____
Drink alcoholic beverages? ❑ Yes ❑ No
If yes, how many a week? _____

Have you ever had:
Orthodontic treatment (braces)? ❑ Yes ❑ No
Oral Surgery? ❑ Yes ❑ No
Periodontal treatment of the gums? ❑ Yes ❑ No
Your teeth ground or the bite adjusted? ❑ Yes ❑ No
A night guard? ❑ Yes ❑ No
A serious injury to the mouth? ❑ Yes ❑ No

Have you ever experienced:
Clicking or popping of the jaw? ❑ Yes ❑ No
Joint, ear or side of face pain? ❑ Yes ❑ No
Difficulty closing or opening mouth? ❑ Yes ❑ No
Chronic headaches, neck aches, or shoulder aches? ❑ Yes ❑ No