

PATIENT INFORMATION

Patient's Name _____
First MI Last

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-Mail Address _____

SS# _____ Date of Birth _____

Please check the appropriate box: Minor Single Married Divorced Widowed

If you are a college student: Full-time Part-time Name of School: _____

Patient's or Parent's/Guardian's Employer _____

Spouse or Parent's/Guardian's Name _____

Whom may we thank for referring you to Dr. Crosby? _____

Person to contact in case of an emergency _____ Phone _____

RESPONSIBLE PARTY INFORMATION

Name of person responsible for payment of this account _____

Relationship to patient _____ Home Phone _____ Work Phone _____

Address _____

SS# _____ Date of Birth _____

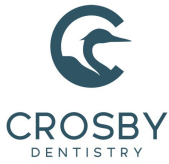
Is this person currently a patient in this office? YES NO

I authorize Dr. Crosby to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I also authorize the following person(s) to receive information regarding my treatment, diagnosis, finances, and appointments:

I agree to be responsible for payment for all services rendered on my behalf or my dependents. If I have dental insurance, I understand that, as a courtesy to me, a staff person will be assigned to assist in attempting to verify dental insurance coverage, determine the limitations of my policy, identify the maximum dental insurance benefits, and assist in filing the necessary forms, so that benefits to which I am entitled may be received up to the maximum allowable amount. I authorize and request my insurance company to make payment directly to Dr. Brian Crosby, unless otherwise payable to me. I also understand Signature of patient or parent/guardian, if minor that there is no guarantee of insurance coverage or payment and that my dental insurance carrier may deny payment or payless than the actual bill for services, for any reason they may choose.

X _____ Date _____

Signature of patient or parent/guardian, if minor



PATIENT MEDICAL HISTORY

Patient's Name _____
First MI Last

Are you under the care of a physician? YES NO If so, reason: _____

Physician's Name _____ Phone Number _____

Date of last medical examination: _____

Do you use tobacco (cigarettes, chewing tobacco, or snuff)? YES NO If so, how many times per day? _____

If you are a female: Are you pregnant? YES NO Are you taking birth control pills? YES NO

Are you nursing? YES NO

PLEASE LIST ANY MEDICATIONS:

Medication: _____ Milligrams _____ Reason _____

Medication: _____ Milligrams _____ Reason _____

Medication: _____ Milligrams _____ Reason _____

Medication: _____ Milligrams _____ Reason _____

Medication: _____ Milligrams _____ Reason _____

Please indicate if you have or have had any of the following diseases or problems:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> HIV + AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Taken Fen-Phen |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Taking Aspirin |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer/Radiation/Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Colitis/Acid Reflux/Crohn's Disease | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rheumatic Fever | |

ALLERGIES — Please indicate if you have allergies:

- | | | | |
|---|---------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metals | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Jewelry | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Other _____ |

OSTEOPOROSIS MEDICATIONS

Are you taking or scheduled to begin taking osteoporosis medications? YES NO If so, which medication:

Fosamax Actonel Boniva How long have you be taking this medication? _____

Have you been treated for osteoporosis, bone pain, hypercalcemia, or skeletal complications with intravenous (IV) bisphosphonates? (Aredia or Zometa) YES NO

Signature _____ Date _____

Brian Crosby, DMD
Your Privacy Is Important to US

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Brian Crosby, D.M.D. I hereby authorize, as indicated by my signature below, Brian Crosby, D.M.D. to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Print Name

Name of Child/Children, if applicable

Signature

Date

Please check your preferred means of communication:

- You may contact me at my home telephone number _____
- You may contact me on my mobile telephone number _____
- You may contact me on my work telephone number _____
- You may send me an email at: _____
- Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed: _____
2. _____ Date Added / Removed: _____
3. _____ Date Added / Removed: _____
4. _____ Date Added / Removed: _____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
But acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify) _____