Crestline Village Dentistry

M. Clark Dunn, D.M.D
244 Country Club Park
Mountain Brook, AL 35213 205.870.5700

First Name:_____ MI:_____ Last:_____ Nick Name: _____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

DOB:_____ ☐ Male ☐ Female SS#: _____

Address:_____ City:_____ State:_____ Zip: _____

Employer: _____

E-mail Address:_____

Name of Physician:_____ Physician Phone: _____

In case of Emergency Contact:_____ Relationship:_____ Phone: _____

How did you hear about our office? _____

Patient Health History

Y	N		Y	N		Y	N		Y	N	
		AIDS/ HIV Positive			Diabetes			HPV			Psychiatric Care
		Allergies			Epilepsy/Seizures			Hypoglycemia			Reflux
		Anemia			Excessive Bleeding			Irregular Heartbeat			Respiratory Problems/Disease
		Arthritis			Fainting/Dizziness			Jaundice			Rheumatic Fever
		Artificial Heart Valve/Murmur			Frequent Headache			Kidney Dialysis			Rheumatism
		Artificial Joint			Hearing Impaired			Kidney Disease			Scarlet Fever
		Asthma			Heart Attack/Failure			Liver Disease			Sinus Trouble
		Blood Disease			Heart Pacemaker			Low Blood Pressure			Stomach/Intestinal Disease
		Bone Disease			Heart Trouble/Disease			Lupus			Stroke
		Cancer			Hepatitis A			Mitral Valve Prolapse			Thyroid Disease
		Chemo/Radiation			Hepatitis B or C			Neck/Back Problems			Tuberculosis
		Chest Pains			High Blood Pressure			Nervous Problems/Disorder			Ulcers
		Circulatory Problems			High Cholesterol			Osteoporosis			

Medical History

List any medications you are taking including non prescription drugs:

_____

_____

Do you have any disease/problem you think we should know about? ☐ Yes ☐ No

_____

_____

Are you allergic to anything or any of the following?

Acrylic	☐	Keflex	☐
Amoxicillin	☐	Latex	☐
Aspirin	☐	Omnicef	☐
Bactrim	☐	Metal	☐
Clindamycin	☐	Penicillin	☐
Codeine	☐	Sulfa Drugs	☐
Erythromycin	☐	Tetracycline	☐
Keflex	☐	Other: _____	

	Yes	No
Have you had a transplant operation that has depressed your immune system?		
Have you had heart surgery?		
Have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, etc.)		

	Yes	No
Do you smoke, chew tobacco, or vape?		
Are you under the care of an MD now?		

Have you ever been hospitalized? Yes ☐ No ☐ If yes, what was the problem _____

_____

Date of last medical exam: _____

FOR WOMEN ONLY:

	Y	N
Are you taking birth control pills?	☐	☐
Are you pregnant?	☐	☐

	Y	N
Are you nursing/breastfeeding?	☐	☐

Expected delivery date: _____

FOR MINORS ONLY:

	Y	N
Has patient received MMRV vaccine?	☐	☐

Dental History

Date of last dental exam: _____

Name of previous dentist: _____

Reason for today's visit: _____

Have you ever had an oral cancer screening? ☐ Yes ☐ No

How often do you floss your teeth? _____

Do your gums bleed when you brush? ☐ Yes ☐ No

Have you or a family member ever been treated for periodontal disease? ☐ Yes ☐ No

Have you ever had complications from an extraction? ☐ Yes ☐ No

Have you ever had a popping or clicking sound near your ear when you chew? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Are you prone to frequent headaches? ☐ Yes ☐ No

Do you have cold sores, ulcers, or swelling on your gums, lips, or cheeks frequently? ☐ Yes ☐ No

Have you ever had orthodontic treatment? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Have you ever been diagnosed with sleep apnea or participated in a sleep study? ☐ Yes ☐ No

Do you have problems with bad breath? ☐ Yes ☐ No

Have you ever had an allergic reaction to a crown, metal filling, or dental appliance? ☐ Yes ☐ No

Do you currently use an electric toothbrush? ☐ Yes ☐ No

Are your teeth sensitive to hot, cold, or pressure? ☐ Yes ☐ No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile, what would it be? Check all that apply.

☐ whiter
☐ straighter
☐ close space
☐ repair chipped teeth
☐ replace missing teeth
☐ less gums showing
☐ replace old crowns/caps that do not match
☐ replace silver fillings with tooth colored restorations

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Photo Consent: I consent that *Crestline Village Dentistry* may use photographs and/or videos of my teeth taken during my dental visits on their social media tools. I understand that these images and/or videos will not be used for any other commercial purposes. ☐ Yes ☐ No

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

Payment Arrangement Form

NAME OF PATIENT: _____

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1) a late fee if payment on my account is not received by the due date; 2) an amount equal to $35.00, but not to exceed the maximum amount permitted by law for each returned check, and 3) a fee for each appointment that is missed/canceled without at least 24 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

RESPONSIBLE PARTY:

Full Name:_____ DOB:_____ SSN#: _____

Street Address:_____

City:_____ State:_____ Zip: _____

Home Phone:_____ Work phone:_____

Employer Name: _____

INSURANCE INFORMATION:

Primary Insurance:

Primary Insurance Name:_____ ID Number:_____ Group Number: _____

Name of Insured:_____ Relationship:_____ Insured Date of Birth: _____

I acknowledge having received a copy of the Practice's Notice of Privacy Practices. I agree that a photocopy of this authorization is as valid as the original.

Signature of Responsible Party: _____ Date: _____

(to be signed even if Patient is also the Responsible Party)