CROSDENTAL
Family, Cosmetic and Implant Dentistry

Welcome! Thank you for choosing our office for your dental health needs. Please let us know if you need assistance when completing these forms.

PATIENT INFORMATION

Name _____ _____
Last Middle First Your preferred name

Email address_____Date of Birth_____

Please check: Married Single Domestic Partner Widowed

Driver's License #_____ Social Security #_____

Phone numbers Home _____Work _____Cell _____

Physical address _____
Street Apt # City State Zip

Mailing address _____
(If different than above) Street Apt # City State Zip

Name of Spouse, Partner or Parent_____

Emergency Contact Person _____
Name Relationship Phone Number

Who may we thank for referring you? _____

PATIENT'S DENTAL INSURANCE

Name of Insured _____ Social Security #_____

Date of Birth _____ Relationship to Patient _____

Name of Ins. Company _____ Group/Policy# _____

Employer Name _____ Occupation _____

SECONDARY DENTAL INSURANCE

Name of Insured _____ Social Security #_____

Date of Birth _____ Relationship to Patient _____

Name of Ins. Company _____ Group/Policy# _____

Employer Name _____ Occupation _____

DENTAL HISTORY

Name of Previous Dentist _____ Last Visit_____

Reason for Last Visit _____ X-rays taken_____

Present Dental Concern _____

How often do you brush your teeth?_____ Floss?_____

Type of toothbrush used: ☐Manual ☐Electric ☐Medium Bristle ☐Soft Bristle

Check all used: ☐Mouthwash ☐Rubber Tip ☐WaterPik ☐Proxabrush ☐Toothpicks ☐Other

How often are your teeth cleaned? ☐3 mos. ☐4 mos. ☐6 mos. ☐1 year ☐Other

My Dental Health is: ☐Excellent ☐Good ☐Fair ☐Poor

PLEASE CHECK YES OR NO FOR THE FOLLOWING:

Do you have sensitive or sore teeth	Yes ☐	No ☐	Do you have any popping, clicking, or pain in your jaw?	Yes ☐	No ☐
Do your gums bleed when you brush or floss?	Yes ☐	No ☐	Does your jaw ever lock?	Yes ☐	No ☐
Do you have an unpleasant taste or odor in your mouth?	Yes ☐	No ☐	Do you have trouble opening your mouth widely?	Yes ☐	No ☐
Do you have a dry mouth?	Yes ☐	No ☐	Do you clench or grind your teeth?	Yes ☐	No ☐
Does food or floss catch between your teeth?	Yes ☐	No ☐	Do you have earaches, neck pain or tension headaches?	Yes ☐	No ☐
Have you lost any teeth? Reason:	Yes ☐	No ☐	Do you currently wear any type of night guard or splint for TMJ?	Yes ☐	No ☐
Have you ever had an injury to your mouth, head, or teeth?	Yes ☐	No ☐	Have you ever had orthodontic treatment or braces?	Yes ☐	No ☐
Have you ever had a dental infection or abscess?	Yes ☐	No ☐	Is your home water supply fluoridated?	Yes ☐	No ☐
Do you have any lumps or swelling in your mouth?	Yes ☐	No ☐	Do you drink bottled water?	Yes ☐	No ☐
Do you have any pain or difficulty swallowing?	Yes ☐	No ☐	Are you anxious about dental visits?	Yes ☐	No ☐
Do you ever have mouth sores (canker sores, cold sores)?	Yes ☐	No ☐	Have you had any problems with the effectiveness of dental anesthetics?	Yes ☐	No ☐
Have you ever had treatment for gum	Yes ☐	No ☐	Are you happy with the appearance of your teeth and smile?	Yes ☐	No ☐
Do you have any jaw problems or TMJ?	Yes ☐	No ☐			

Do you wear dentures or partials? If so, please complete the following:

When was the appliance made?_____

Name of Dentist providing the appliance _____

Has your appliance ever been relined? Yes ☐ No ☐

Has your appliance ever been repaired? Yes ☐ No ☐

Does your denture or partial fit well? Yes ☐ No ☐

Do you need adhesive to keep your appliance in place? Yes ☐ No ☐

71843 Highway 111, Suite A Rancho Mirage, CA 92270 (760)444-3202 office (760)444-3229 fax email:info@crosdental.com

MEDICAL HISTORY

Name of Physician:_____Phone ( ) _____

Address/City/State_____

Date of last physical exam?_____

PLEASE CHECK YES OR NO FOR ALL OF THE FOLLOWING:

Abnormal Bleeding	Yes ☐	No ☐	Heart Murmur	Yes ☐	No ☐
Allergies/Hay Fever	Yes ☐	No ☐	Heart Pacemaker	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Heart Surgery	Yes ☐	No ☐
Angina	Yes ☐	No ☐	Hemophilia	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Hepatitis: Type A☐ Type B☐ Type C☐	Yes ☐	No ☐
Artificial Joint	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐
Artificial (prosthetic) Heart	Yes ☐	No ☐	HIV/AIDS	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Autoimmune Disease	Yes ☐	No ☐	Joint Replacement	Yes ☐	No ☐
Bisphosphonate Use (Actonel, Fosamax, Boniva, etc.)	Yes ☐	No ☐	Kidney Problems	Yes ☐	No ☐
Blood Transfusion	Yes ☐	No ☐	Liver Disease	Yes ☐	No ☐
Breathing Problems	Yes ☐	No ☐	Low Blood Pressure	Yes ☐	No ☐
Bronchitis	Yes ☐	No ☐	Lupus	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Mental Health Disorders	Yes ☐	No ☐
Chemical Dependency	Yes ☐	No ☐	Migraine Headaches	Yes ☐	No ☐
Chemotherapy	Yes ☐	No ☐	Mitral Valve Prolapse	Yes ☐	No ☐
Chronic Pain	Yes ☐	No ☐	Neurological Disorder	Yes ☐	No ☐
Congenital Heart Defect	Yes ☐	No ☐	Osteoporosis	Yes ☐	No ☐
Congestive Heart Failure	Yes ☐	No ☐	Radiation Treatment	Yes ☐	No ☐
Cough for longer than 3 weeks	Yes ☐	No ☐	Respiratory Problems	Yes ☐	No ☐
Cough that produces blood	Yes ☐	No ☐	Rheumatic Fever	Yes ☐	No ☐
Diabetes: Type I☐ Type II☐	Yes ☐	No ☐	Rheumatic Heart Disease	Yes ☐	No ☐
Eating Disorder	Yes ☐	No ☐	Sexually Transmitted Disease	Yes ☐	No ☐
Emphysema	Yes ☐	No ☐	Sickle Cell Disease	Yes ☐	No ☐
Epilepsy or Seizures	Yes ☐	No ☐	Sinus Problems	Yes ☐	No ☐
Excessive Thirst	Yes ☐	No ☐	Sleep Apnea	Yes ☐	No ☐
Excessive Urination	Yes ☐	No ☐	Sleep Disorder	Yes ☐	No ☐
Fainting or Dizziness	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Frequent Cough	Yes ☐	No ☐	Surgical Shunt	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐	Swollen Glands	Yes ☐	No ☐
Heartburn or Reflux	Yes ☐	No ☐	Thyroid Problems	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Ulcers	Yes ☐	No ☐
Heart Infection (Endocarditis or Pericarditis)	Yes ☐	No ☐			

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MEDICAL HISTORY (continued)

Do you have any health problems not listed above? Yes ☐ No ☐

If yes, please explain_____

_____

Have you been in the hospital or had a serious illness in the last 5 years? Yes ☐ No ☐

If yes, please explain_____

_____

Are you taking any prescription medications? Yes ☐ No ☐

If so, please list_____

_____

_____

Are you using over-the-counter meds, herbal meds, or other supplements? Yes ☐ No ☐

If so, please list_____

_____

Are you allergic to any medications or substances? Please check boxes below:

☐ Aspirin ☐ Penicillin ☐ Sulfa Drugs ☐ Tetracycline ☐ Other Antibiotics
☐ Local Anesthetics ☐ Codeine or other Narcotics ☐ Sleeping Pills ☐ Iodine
☐ Metal ☐ Latex ☐ Acrylic ☐ Other, please list_____

Have you ever used tobacco? Yes ☐ No ☐

If yes, how long, type and amount_____

Do you drink alcoholic beverages? Yes ☐ No ☐

How often and how much? _____

Women (please check) ☐ Pregnant ☐ Trying to get pregnant ☐ Nursing
☐ Using Oral Contraceptives ☐ Hormone Replacement Therapy

To the best of my knowledge, all of the above answers are correct. If I have any changes in my health status, I will inform the dentist and the staff before my next appointment.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

_____ _____

Signature of Dentist Date

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APPOINTMENT CANCELLATION POLICY

We value your time and make every effort to see you on time for your appointments. When you schedule an appointment with us, this time is reserved exclusively for you. Any change in this appointment affects many people, so we require notice of two business days (48hrs) if you are unable to keep your appointment. *Please Note: We reserve the right to dismiss a patient from our practice for repeated "No Show" or same day cancellations. Signing this form indicates that you understand and will comply with our cancellation policy.

FINANCIAL POLICY

Payment for your dental treatment is due at the time of service, unless financial arrangements are made prior to treatment. This policy is instrumental in helping us keep dental care costs down for our patients by reducing the significant expenses associated with billing procedures. There is a $25.00 fee for each returned check and balances over 60 days are subject to interest at the rate of 1.5% per month at our discretion. We offer 3rd party financing through Care Credit and Lending Club in addition to credit card, cash, and check payments. $150-refundable deposit is required to schedule appointments for procedures such as: crown/veneers, root canal, implant, and periodontal procedures. The deposit is non-refundable should you cancel the appointment without full 24 hour notice during our normal business hours.

DENTAL INSURANCE POLICY

We are happy to submit your insurance claim, but please remember that your insurance plan does not guarantee payment will be made on your behalf. Any procedures "not covered" by your plan will be provided to you at our fee for service rate. We make every effort to estimate your co-payments and to help you understand your benefits. The patient is ultimately responsible for any amount not paid by insurance. We reserve the right to modify this policy at any time without further notice. Signing this form indicates that you understand and will comply with our financial policy.

AUTHORIZATION AND CONSENT

I agree and consent to dental examination by this office. I understand that diagnostic procedures and dental treatments may be recommended and will be discussed in advance. To the best of my knowledge, I have completed this paperwork accurately and I will bring all future changes in my medical or dental history to the attention of the doctor. I understand that providing incorrect or incomplete information can be dangerous to my health. I grant permission for the office to contact me at home or work via telephone, email, or text messages. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

I authorize the release of information needed to process my insurance claims. I authorize my insurance benefits to be paid directly to this dental office.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

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