Melvin E. Cruser, DDS

DATE_____ **GENERAL AND COSMETIC DENTISTRY**

A Division of Atlantic Dental Care, PLC

WELCOME TO OUR PRACTICE!

PATIENT NAME_____ DOB_____ M / F

MARITAL STATUS _____ SSN_____

HOME ADDRESS _____

EMAIL ADDRESS _____ PHONE #'S H:_____W:_____ C:_____

WHERE AND WHEN ARE THE BEST TIMES TO REACH YOU _____

EMPLOYER _____OCCUPATION_____ SPOUSE/PARENT NAME_____

SPOUSE/PARENT EMPLOYER AND WORK #_____

NEAREST RELATIVE NOT LIVING WITH YOU _____

ADDRESS _____ PHONE#_____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT) _____RELATION_____

ADDRESS_____ WORK #_____HOME #_____

LET US KNOW HOW YOU HEARD ABOUT OUR OFFICE: (CIRCLE ONE) VERIZON SUPERPAGES, YELLOWBOOK, INTERNET (Our website, Superpages, or Yellowbook), LOCATION, INSURANCE LIST, 1-800 DENTIST (TV AD, PHONEBOOK, OR WEBSITE), FRIEND OR FAMILY MEMBER (name)_____.

SIGNATURE_____
I authorize treatment

INSURANCE INFORMATION

INSURANCE COMPANY_____ PHONE #_____ ID #_____

GROUP #_____

INSURED'S NAME _____ SSN_____ DOB_____

EMPLOYER_____

DENTAL AND ORAL HEALTH INFORMATION

PURPOSE OF TODAY'S VISIT _____DATE OF LAST

DENTALVISIT_____NAME OF PREVIOUS DENTIST_____ WHAT WAS DONE

AT YOUR LAST VISIT _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Check all that apply)

__Toothaches
__ Bleeding Gums
__ Local Anesthetic
__ General Anesthetic
__ Pain or clicking when jaw opens or closes
__ Braces
__ Nitrous Oxide
__ Sores on lips/ mouth
__ Extractions
__Infections
__ Broken Jaw
__ Difficulty fitting teeth together

IF YOU HAVE DENTURES OR PARTIAL DENTURES, HOW OLD ARE THEY? _____ ARE YOU HAPPY WITH THE WAY YOUR SMILE LOOKS? YES ____ NO_____ IF NOT, WHAT WOULD YOU CHANGE? _____

_____. DO YOU HAVE AN INTEREST IN COSMETICALLY ENHANCING YOUR SMILE? _____

MEDICAL HISTORY

Has there been any change in your general health in the last 5 years? _____ Date of last physical exam _____
Name of Physician _____ Have you had any serious illness, surgery , or hospitalization in the last 5 years? If yes, what _____.

CHECK ANY OF THE FOLLOWING THAT YOU HAVE (OR HAD):

__ HEART MURMUR
__ PACEMAKER
__ HEART DISEASE
__HIGH BLOOD PRESSURE
__ EPILEPSY
__ ULCERS
__ HEPATITIS
__ ASTHMA
__ ARTIFICIAL JOINTS
__ HEART VALVES
__ NEURALGIA
__ LOW BLOOD PRESSURE
__ FAINTING SPELLS
__ ANEMIA
__ PNEUMONIA
__ JAUNDICE
__ METABOLIC PROBLEMS
__ KIDNEY PROBLEMS
__ RHEUMATIC FEVER
__ AIDS/HIV
__ DIABETES
__ THYROID PROBLEMS
__ PSYCHIATRIC CARE
__BLEEDING PROBLEMS
__TUBERCULOSIS
__VENEREAL DISEASE
__ARTHRITIS
__MENINGITIS
__ CANCER
__ HERPES
__ HEAD INJURY
__ HEART SURGERY

HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH ANY PREVIOUS EXTRACTIONS/SURGERY? _____

ARE YOU TAKING ANY DRUGS OR MEDICATIONS (INCLUDING OVER THE COUNTER)? ___YES ___NO

PLEASE LIST _____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY MEDICATION INCLUDING LOCAL ANESTHETICS (NOVOCAINE)? _____PENICILLIN?_____ OTHER (PLEASE LIST) _____

ARE YOU PREGNANT? _____ IF YES, HOW MANY MONTHS?_____

DO YOU SMOKE? _____ HOW MANY PACKS A DAY?_____

PLEASE LIST ANY OTHER INFORMATION THAT SHOULD BE KNOWN ABOUT YOUR HEALTH?_____

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