

MELVIN E. CRUSER, III DDS
GENERAL AND COSMETIC DENTISTRY
WELCOME TO OUR PRACTICE!

DATE _____

PATIENT INFORMATION

PATIENT'S FULL NAME _____ DOB _____

MALE__ FEMALE__ MARITAL STATUS _____ SS# _____

HOME ADDRESS _____

Street City State Zip

EMAIL ADDRESS _____ HOME PHONE _____

CELL PHONE _____ WORK PHONE _____

WHERE AND WHEN ARE THE BEST TIMES TO REACH YOU _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____

SPOUSE/PARENT NAME _____ SPOUSE/PARENT EMPLOYER AND WORK # _____

NEAREST RELATIVE NOT LIVING WITH YOU _____

ADDRESS _____ PHONE # _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT) _____

RELATION _____ WORK PHONE _____ HOME PHONE _____

ADDRESS _____

SIGNATURE _____

I authorize treatment.

INSURANCE INFORMATION

COMPANY NAME _____ POLICY # _____

PHONE # _____ INSURED'S NAME _____

INSURED'S SS# _____ INSURED'S DOB _____

INSURED'S EMPLOYER _____

PLEASE LET US KNOW HOW YOU HEARD ABOUT OUR OFFICE:

Please circle one

VERIZON YELLOWPAGES YELLOWBOOK INTERNET (Our website, Superpages, or Yellowbook)

LOCATION INSURANCE LIST 1-800 Dentist (TV ad, phonebook, or website)

FRIEND OR FAMILY MEMBER _____

DO YOU HAVE AN INTEREST IN COSMETICALLY ENHANCING YOUR SMILE? YES__ NO__

PURPOSE OF TODAY'S VISIT _____

DENTAL HISTORY

DATE OF LAST DENTAL VISIT _____ NAME OF PREVIOUS DENTIST _____

WHAT WAS DONE AT YOUR LAST VISIT _____

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

TOOTHACHES BRACES EXTRACTIONS INFECTIONS BROKEN JAW

BLEEDING GUMS SORES ON LIPS OR IN MOUTH DIFFICULTY FITTING YOUR TEETH TOGETHER

LOCAL ANESTHETIC PAIN OR CLICKING WHEN YOUR JAW OPENS OR CLOSES

GENERAL ANESTHETIC NITROUS OXIDE

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? _____

MEDICAL HISTORY

HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE LAST 5 YEARS? YES NO

DATE OF LAST PHYSICAL EXAM _____ NAME OF PHYSICIAN _____

HAVE YOU HAD ANY SERIOUS ILLNESS, SURGERY, OF HOSPITALIZATION IN THE LAST 5 YEARS? IF YES, WHAT

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

- HEART MURMUR ARTIFICIAL JOINTS NEURALGIA PNEUMONIA AIDS /HIV
- PACEMAKER OR HEART VALVES ARTHRITIS JAUNDICE DIABETES
- OPEN HEART SURGERY HEPATITIS FAINTING SPELLS METABOLIC PROBLEMS THYROID PROBLEMS
- HEART DISEASE ASTHMA ANEMIA KIDNEY PROBLEMS PSYCHIATRIC CARE
- HIGH BLOOD PRESSURE LOW BLOOD PRESSURE RHEUMATIC FEVER CANCER
- EPILEPSY HERPES HEAD INJURY TUBERCULOSIS
- ULCERS BLEEDING/CLOTTING PROBLEMS MENINGITIS VENEREAL DISEASE

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

ARE YOU TAKING ANY DRUGS OR MEDICATIONS (INCLUDING OVER THE COUNTER MEDICATIONS) ? YES NO

PLEASE LIST _____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY MEDICATIONS INCLUDING LOCAL ANESTHETICS

(NOVOCAINE)? _____ PENICILLIN? _____

OTHER (PLEASE LIST) _____

ARE YOU PREGNANT? YES NO IF YES, HOW MANY MONTHS? _____

DO YOU SMOKE YES NO HOW MANY PACKS/DAY? _____

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

GENERAL INFORMATION

THE FOLLOWING IS DESIGNED TO GIVE YOU SOME BASIC INFORMATION ABOUT OUR PRACTICE, WHICH WE HOPE WILL FOSTER A PLEASANT AND REWARDING RELATIONSHIP BETWEEN YOU AND DR. CRUSER. WE HAVE TRIED TO ANTICIPATE AND PROVIDE THE ANSWERS TO MANY COMMON QUESTIONS WE ENCOUNTER AND WILL ALWAYS BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE. BE ASSURED THAT WE WILL DO THE UTMOST TO CARE FOR YOUR INDIVIDUAL DENTAL NEEDS.

OFFICE HOURS AND APPOINTMENTS

REGULAR OFFICE HOURS ARE AVAILABLE BETWEEN 8 AM AND 6PM. YOUR APPOINTMENTS ARE RESERVED TIME FOR YOU AND YOU ALONE. WE DO OUR BEST TO PROVIDE CONFIRMATION AND REMINDER PHONE CALLS, HOWEVER IT IS NOT ALWAYS POSSIBLE TO REACH YOU. IT IS YOUR RESPONSIBILITY TO NOTIFY US AT LEAST 24 HOURS IN ADVANCE IF YOU NEED TO RESCHEDULE YOUR APPOINTMENT. APPOINTMENTS MISSED WITHOUT PROPER 24 HOUR NOTIFICATION MAY BE CHARGED A FEE BASED ON THE LENGTH OF THE APPOINTMENT.

_____ INITIAL

FINANCIAL POLICY

WE ARE GLAD TO FILE YOUR INSURANCE CLAIMS AS A SERVICE TO YOU. OUR GOAL IS TO MAXIMIZE YOUR INSURANCE BENEFITS. SINCE WE DO NOT HAVE ACCESS TO YOUR INDIVIDUAL POLICY INFORMATION, WE ASSUME NO LIABILITY. IT IS YOUR RESPONSIBILITY TO REVIEW YOUR INDIVIDUAL INSURANCE POLICY AND BENEFITS. ALL CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. THE ULTIMATE RESPONSIBILITY FOR PAYMENT IS YOURS. FOR YOUR CONVENIENCE, OUR OFFICE ACCEPTS VISA, MC, AE, DISCOVER, CHECKS AND CASH. THERE IS A SERVICE CHARGE ON ALL CHECKS RETURNED FOR INSUFFICIENT FUNDS. IF YOU WOULD LIKE TO MAKE PAYMENTS, ASK ABOUT OUR FINANCING OPTIONS THROUGH CARECREDIT. ANY ACCOUNTS OVER 60 DAYS PASTDUE, WITHOUT PRIOR FINANCIAL ARRANGEMENTS, WILL BE REFERRED TO AN ATTORNEY FOR COLLECTION. IF YOUR ACCOUNT IS REFERRED TO AN ATTORNEY FOR COLLECTION YOU AGREE TO PAY ANY ATTORNEY AND COURT COSTS.

SIGNATURE _____ DATE _____