ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

" YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT "

I, _____ , Have received a copy of this office's Notice of Privacy Practices.

_____

Printed Name

_____

Signature

_____

Date

_____

FOR OFFICE USES ONLY

_____

We attempt 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**

_____ **A emergency situation prevented us from obtaining acknowledgement**

_____ **Other (Please Specify)**

_____

_____

_____

DR. Patrick Crawford DDS

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NO SHOW POLICY

Due to high demand of appointments and in order to be respectful of the medical needs of all our patients please be courteous and call our office promptly if you are unable to attend an appointment. We always have patients on a cancellation list that need care.

If you are unable to keep your scheduled appointment we require 24 hour notice.

There will be a $25 charge for every appointment miss without proper notification as mentioned above.

If you miss 3 appointments without proper notification we reserve the right to dismiss the patient from care.

_____

Signature Date

ADULT INFORMATION FORM
OR RESPONSIBLE PARTY

Patient's Name:_____ Nickname:_____

D.O.B.:_____ Social Security #:_____

Home Phone:_____ Cell Phone:_____

E-mail:_____
(We don't give or sell this to any other people)

Address:_____ C/S/Zip:_____

Are you: Married_____ Separated_____ Divorced_____ Single____

Employer:_____ How Long:_____ Occupation:_____

Work Phone:_____ May we contact you or leave a message?_____

Are you the policy holder for insurance? YES___ NO___

Whom may we thank for referring you to our office?_____

***UNLESS OTHERWISE SPECIFIED, YOU ARE CONSIDERED RESPONSIBLE FOR YOUR ACCOUNT.**

OTHER RESPONSIBLE PARTY INFORMATION and/or EMERGENCY CONTACT

Name:_____ Social Security #:_____

D.O.B.:_____ Relationship to Patient:_____

Address (if different):_____ C/S/Zip:_____

Home Phone:_____ Cell Phone:_____

Employer:_____ How Long:_____ Occupation:_____

Work Phone:_____ May we contact you or leave a message?_____

Are they the policy holder for insurance? YES___ NO___

DENTAL INSURANCE INFORMATION

Member ID:_____Group #_____

Insurance Company:_____ Insurance Phone #:_____

Insurance Company Address with C/S/Z:_____

Do you have dual coverage? YES____ NO____ **If yes, Please fill in below.**

Member ID:_____Group #_____

Insurance Company:_____ Insurance Phone #:_____

Insurance Company Address with C/S/Z:_____

DENTAL HISTORY

Former Dentist: _____

Date of Last Dental Visit: _____

Date of Last X-Rays: _____

How Often Do You Floss? _____

How Often Do You Brush? _____

Please check all that apply:

Bad Breath ☐	Loose Teeth or Broken Fillings ☐	Sensitivity to Sweets ☐
Bleeding Gums ☐	Orthodontic Treatment ☐	Sensitivity When Biting ☐
Blisters on Lips or Mouth ☐	Pain Around Ear ☐	Frequent Headaches ☐
Finger Nail Biting ☐	Periodontal Treatment ☐	Jaw, Head, or Neck Injuries ☐
Grinding Teeth ☐	Sensitivity to Cold ☐	Jaw Difficulty: Clicking and/or Pain ☐
Lip or Cheek Biting ☐	Sensitivity to Heat ☐	Tooth Pain ☐

MEDICAL HISTORY

Physician's Name: _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol?	☐	☐
6. Do you use recreational drugs?	☐	☐
7. Do you wear contact lenses?	☐	☐

8. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetic (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Latex	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

9. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

AIDS ☐	Diabetes-Type____ ☐	Nervous Problems ☐
Anemia ☐	Emphysema ☐	Pacemaker ☐
Arthritis, Rheumatism ☐	Epilepsy ☐	Psychiatric Care ☐
Artificial Heart Valves ☐	Fainting or Dizziness ☐	Radiation Treatment ☐
Artificial Joints ☐	Glaucoma ☐	Respiratory Disease ☐
Asthma ☐	Headaches ☐	Rheumatic Fever ☐
Back Problems ☐	Heart Murmur ☐	Scarlet Fever ☐
Bleeding abnormally, with extraction's or surgery ☐	Heart Problems ☐	Shortness of Breath ☐
	Hepatitis-Type____ ☐	Sinus Trouble ☐
	Herpes ☐	Skin Rash ☐
Blood Disease ☐	High Blood Pressure ☐	Stroke ☐
Cancer ☐	HIV Positive ☐	Swelling of Feet/Ankles ☐
Chemical Dependency ☐	HPV ☐	Swollen Neck Glands ☐
Chemotherapy ☐	Jaundice ☐	Thyroid Problems ☐
Circulatory Problems ☐	Jaw Pain ☐	Tonsillitis ☐
Congenital Heart Lesions ☐	Liver Diseased ☐	Tuberculosis ☐
Cortisone Treatments ☐	Kidney Disease ☐	Tumor or growth on head/neck ☐
Cough-persistant & bloody ☐	Low Blood Pressure ☐	Ulcer ☐
	Mitral Valve Prolapse ☐	Venereal Disease ☐

ASSIGNMENT

I hereby authorize payment directly to **Dr. Crawford** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to sercure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____