Crown Dental, Inc.
Family & Cosmetic Dentistry
4812 N. Habana Avenue, Tampa, FL 33614
Phone: (813)873-0271 - Fax (813)873-2929

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill this form out completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Esta forma esta disponible en Español.

Patient #:_____
Soc. Sec. #:_____
Date: _____

Patient Information (Confidential)

Name _____ DOB _____ Home Phone _____
E-mail _____ Cell Phone _____
Home Address _____ City _____ State _____ Zip_____
Check Appropriate: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Work Phone _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
If a patient is a student, name of school/college _____ City _____ State _____
How did you hear about us? ☐Friend ☐ Website ☐ Facebook ☐Other _____
Person to contact in case of emergency _____ Relation _____ Phone _____
Pharmacy Name _____ Phone _____

Responsible Party

Name of person responsible for account _____ Relationship to patient _____
Address _____ City _____ State _____ Zip _____
Driver's License# _____ DOB _____ Financial Institution _____
Employer _____ Work Phone_____
Is this person currently a patient in our office? ☐Yes ☐No

Insurance Information

Name of insured _____ Relationship to patient_____
Primary Insurance Co. _____ Phone_____
Policy Number _____ Group Name _____

Do you have any additional insurance? ☐Yes ☐No If Yes, complete the following.

Secondary Insurance Co. _____ Phone _____
Policy Number _____ Group Name_____

Medical History

Physician _____ Office Phone_____ Date of last exam_____

Are you under medical treatment now?	☐Yes ☐No
Have you ever been hospitalized for a surgical procedure or serious illness?	☐Yes ☐No
Do you have any artificial joints? (knee, hips, etc.) screws or metal plates?	☐Yes ☐No
Are you taking any blood thinners, including Aspirin?	☐Yes ☐No
Do you have sleep apnea (snoring)	☐Yes ☐No
Do you use alcohol?	☐Yes ☐No
Do you use tobacco?	☐Yes ☐No
Do you use cocaine or other drugs?	☐Yes ☐No
Are you allergic? Have you had any reaction to?	
Aspirin	☐Yes ☐No
Antibiotics (penicillin)	☐Yes ☐No
Local anesthetics (epinephrine)	☐Yes ☐No
Sedatives, analgesics (codeine)	☐Yes ☐No
Others (specify if yes) _____	☐Yes ☐No

_____

Do you have or have you ever had any of the following? _____/_____

Heart Disease	☐Yes ☐No	High or low blood pressure	☐Yes ☐No	Cancer	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Cardiac Pacemaker or valves	☐Yes ☐No	Hemophilia	☐Yes ☐No
Rheumatic Fever	☐Yes ☐No	Sexually Transmitted Diseases	☐Yes ☐No	Diabetes	☐Yes ☐No
Kidney Diseases	☐Yes ☐No	AIDS or HIV infection	☐Yes ☐No	Ulcers	☐Yes ☐No
Liver Diseases	☐Yes ☐No	Nervous Disorders	☐Yes ☐No	Glaucoma	☐Yes ☐No
Tuberculosis	☐Yes ☐No	Hepatitis/Jaundice	☐Yes ☐No	Arthritis	☐Yes ☐No
Sinus Problems	☐Yes ☐No	Radiation Therapy	☐Yes ☐No	Stroke	☐Yes ☐No
Nose Bleeding	☐Yes ☐No	Epilepsy/Convulsions	☐Yes ☐No	Thyroid	☐Yes ☐No

Do you have or have you ever had any disease condition or problems not listed? If so, please specify _____

_____

Patient Dental History

When was the last time you went to a dentist? _____

Dentist's Name _____ Office Phone _____

Do you wear dentures or partials? ☐Yes ☐No If yes, how long? _____

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

Do you have any clicking, popping; or tenderness when chewing or opening mouth? ☐Yes ☐No

Do your gums bleed while brushing or flossing? ☐Yes ☐No

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

Do you feel pain on any of your teeth? ☐Yes ☐No

Have you ever had any difficult extractions in the past? ☐Yes ☐No

Have you ever had instructions on the correct method of brushing your teeth? ☐Yes ☐No

Would you like your teeth to look whiter? ☐Yes ☐No

Would you like to improve the color or appearance of old fillings or dental work? ☐Yes ☐No

Women Only

Are you, or do you think you might be, pregnant? ☐Yes ☐No

How many months? _____

Are you nursing? ☐Yes ☐No

Are you taking birth control pills? ☐Yes ☐No

*WARNING: BIRTH CONTROL PILLS MAY BE LESS EFFECTIVE WHEN TAKEN WITH OTHER MEDICATION.
WE STRONGLY RECOMMEND THAT OTHERPRECAUTIONARY MEASURES MAY BE TAKEN.

Authorization for medical attention

The medical history I have given is honest, truthful and complete. I understand that I am also financially responsible for all charges for services rendered to me including deductibles and the balances remaining after payments of possible insurance benefits.

Patient/Parent or Guardian
Signature_____ Date_____ S.S.#_____

MEDICAL UPDATE																											
	CHANGE *YES NO																										
	DOCTOR'S INITIALS																										
	DATE																										