CRYSTAL COAST DENTISTRY
JEFFREY H. SCOTT, DDS PA

PATIENT INFORMATION:

Name_____ Sex: M F Preferred Name _____

Birthdate _____ Age _____ S.S.#_____ Marital Status: Single Married Divorced Widowed Child

Address _____ City _____ State_____ Zip _____

Home Phone _____ Work _____ Cell _____

Email _____

Is it ok to contact you via (check all that apply) ☐ Email ☐ Cell Phone ☐ Text Message ☐ Home ☐ Work

PARENT/GUARDIAN INFORMATION:

Person Responsible for Patient (If different from above) _____ Relation to Patient _____

Birthdate _____ S.S.#_____ Phone _____ Alt. Phone _____

BILLING INFORMATION:

I Do Not have Dental Insurance

- ☐ I would like to pay by cash or check at the time of service
- ☐ I would like to pay by credit card at the time of service
- ☐ I would like to apply for Care Credit Extended Payment Plan

I have Dental Insurance

Insurance Company _____
Guarantor name _____
S.S# _____ D.O.B. _____

- ☐ I would like to pay by cash or check at the time of service
- ☐ I would like to pay by credit card at the time of service
- ☐ I would like to apply for Care Credit Extended Payment Plan

EMERGENCY CONTACT INFORMATION:

Emergency Contact _____ Phone _____

Medical Doctor _____ Phone _____ Date of Last Visit _____

MEDICAL HISTORY:

Have you ever had any serious illnesses or operations? YES NO If yes, please describe _____
Have you ever had a blood transfusion? YES NO If yes, please give approximate date _____
Are you currently taking any blood thiner medications? YES NO
Females: *Are you Pregnant?* YES NO ***Nursing?*** YES NO ***Taking Birth Control Pills?*** YES NO
Please Circle any that apply to you

AIDS
ARTHRITIS
ARTIFICIAL HEART VALVES
ARTIFICIAL JOINTS
ASTHMA
ANXIETY/PANIC ATTACKS
BACK PROBLEMS
BLOOD DISEASE
CANCER
CHEMICAL DEPENDENCY CHEMOTHERAPY
CONGESTIVE HEART FAILURE
DIABETES
EPILEPSY/SEIZURES
FAINTING SPELLS
HEADACHES
HEART MURMUR
HEART CONDITION
BEHAVIORAL PROBLEMS
HEMOPHILIA
HEPTATITIS: Type _____
HIGH BLOOD PRESSURE
HIV POSITIVE
JAW PAIN
KIDNEY DISEASE/DIALYSIS
MITRAL VALVE PROLAPSE
OSTEOPOROSIS
PACEMAKER
IMPLANTED DEFRIBRILLATOR
RESPIRATORY DISEASE
RHEUMATIC FEVER
SCARLET FEVER
SHORTNESS OF BREATH
SICKLE CELL DISEASE/TRAIT
STROKE
TONSILLITIS
TUBERCULOSIS
VENEREAL DISEASE
DEVELOPMENTAL PROBLEMS

Please circle any that you are allergic or sensitive to:

AMOXICILLIN
ANESTHETICS
ASPIRIN
CODEINE
LATEX
TYLENOL

OTHER ALLERGIES: _____

_____

Do you need to be pre-medicated for dental treatment? YES NO

(Normally for patients with a history of heart murmur, artificial joints, mitral valve prolapse, rheumatic fever, sickle cell disease; if unsure, please ask receptionist)

Did you eat prior to the appointment? YES NO **Are you taking any calcium supplements? YES NO**

Please list any medications that you are currently taking: _____

_____

I request and authorize Crystal Coast Dentistry to examine, clean and provide necessary dental treatment for me/the patient. I further request and authorize the taking of dental x-rays/photogra[hs as may be considered necessary for diagnostic or educational purposes. I understand that this office only uses composite (tooth colored) filling material and amalgam (silver) is not available. I will be responsible for any charges incurred on this account.

SIGNATURE _____ **DATE** _____