CrownHillDentistry

G. Thomas Cloyd, DDS, FAGD, FACD • Brittany Gooding, DDS

1792 East State Road 163 • PO Box 408 • Clinton, IN 47842 • **765-832-7741**
Fax 765-832-7743 • CrownHillDentistry.com

1 About you

Today's date: _____

Name: _____

☐ Male ☐ Female

Birthdate: __/__/__ Age: ____ SS# _____

Home Address: _____

Email: _____

☐ Single ☐ Married ☐ Divorced ☐ Widow

Home Phone #: _____

Cell Phone#: _____

Work phone#: _____

Employer: _____

Whom may we thank for referring you?

_____

Other family members seen by us: _____

_____

2 Spouse/Parent Info.

His/Her Name: _____

Employer: _____

Work #: _____ Ext: _____

Birthdate: ___/___/___

* RESPONSIBLE PARTY

Billing Information: _____

Home Phone#: _____

Cell Phone#: _____

Relationship: _____ SS# _____

Employer: _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

3 Dental Insurance

Primary Dental Insurance

Insurance Co.: _____

Insurance Address: _____

Insurance Phone#: _____

Group#: _____

Insured Name: _____

Relation: _____

Insured's Birthdate: __/__/__

Insured's SS#: _____

Insured's Employer: _____

Secondary Insurance

Insurance Co.: _____

Insurance Address: _____

Insurance Co. Phone#: _____

Group#: _____

Insured Name: _____

Relation: _____

Insured's Birthdate: ___/____/____

Insured's SS#: _____

Insured's Employer: _____

4 Medical History

Do you have a physician: Y N

Physician's Name: _____

Phone#: _____ Last Visit: _____

Date Last Physical Exam _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Home #: _____

Cell#: _____

Work#: _____

5 Medical History

Do you have/ had any of the following medical issues:

Y N Heart Attack
Y N Chest pains/Angina
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Heart surgery/Pacemaker
Y N Mitral Valve Prolapse
Y N Rheumatic Fever
Y N Heart Murmur or Defect
Y N Anemia
Y N Heart Burn
Y N Stroke
Y N Cancer-_____
Y N *Chemotherapy*
Y N Radiation Theropy

Y N Depression
Y N Epilepsy/seizures/fainting
Y N Diabetes--Type_____
Y N Tuberculosis (TB)
Y N Drug Abuse
Y N Alcohol Abuse
Y N Hemophilia/bleeding issues
Y N Ulcers/stomach issues
Y N Colitis
Y N Arthritis
Y N Asthma
Y N Hepatitis
Y N *Glaucoma*
Y N HIV+/AIDS

Y N Kidney Problems
Y N Shingles
Y N Artificial Valve
Y N Artificial Joint, If yes where_____
Y N Has premedication been recommended for joint/valve replacement?
If yes, antibiotic recommended_____

FOR WOMEN: Are you taking birth control pills? Y N
Are you pregnant? Y N Week #_____
Are you nursing? Y N

PLEASE LIST ANY MEDICAL CONDITIONS WE SHOULD BE AWARE OF.

_____

_____

6 MEDICATION HISTORY

Please list medications you are currently taking.

_____

_____

Y N Are you taking or ever taken any Bisphosphonates (fosamax, boniva, prolia, etc.)?
Y N Are you taking blood thinners? Please list_____
Y N Any emergency medications (inhaler, nitro tabs, etc?)

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N Penicillin
Y N Erythromycin
Y N Aspirin
Y N Latex

Y N Tetracycline
Y N Dental Anesthetics
Y N Codeine
Y N Sulfa

Other medications:_____

_____

7 DENTAL HISTORY

WHY HAVE YOU COME TO THE DENTIST TODAY?

_____

Y N Are you currently in pain?
Y N Have you ever had difficulties associated with any dental work?_____
Y N Do you like your smile?
Y N Do your gums bleed?
Y N Do you smoke? How much a day?_____
Y N Do you use other forms of tobacco? _____
Y N Are you interested in learning about sedation option, such as conscious sedation or nitrous oxide (laughing gas)?
How many times a day do you brush?_____ Floss?_____

8 TMJ/AIRWAY HISTORY

Y N Do you or have you ever experienced pain/discomfort in your jaw joint ?
Y N Do you experience headaches and if so how many/per week?
_____
Y N *Do you have/had difficulty with opening and or closing?*
Y N Have you ever noticed a clicking in your jaw?
Y N Do you notice yourself clenching or grinding your teeth?
Y N Have you ever had any treatment for TMJ (including splints, night guard, surgery)? If yes what form?_____
Y N Have you ever had orthodontic treatment (braces)?
Y N Do you snore?
Y N Tonsils present?
Y N History of strep/sore throat, yes how often?_____
Y N Have you ever been diagnosed with sleep apnea?
Y N Do you experience daytime tiredness?

Y N Have you had a sleep study?
Y N Do you use a C-PAP?

I understand that the administration of local anesthetic may cause an unfavorable reactions or side effects, which may include, but *are not limited to bruising; hematoma; cardiac stimulation; muscle* soreness; and temporary or rarely, permanent numbness.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that the information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my inform consent that I may need during diagnosis and treatment.

_____

PATIENT/PARENT SIGNATURE DATE:

FOR OFFICE USE

RANGE OF MOTION: O:_____ R:_____ L:_____

DEVIATION: CLOSING : RIGHT LEFT
OPENING: RIGHT LEFT

CLICKING: BI-LAT. RIGHT LEFT

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Acknowledgement of Receipt of Notice of HIPAA Privacy Practices for Crown Hill Dentistry

Brittany D Gooding DDS PC
1792 E State Rd 163, Clinton, IN 47842

* You May Refuse to Sign This Acknowledgment*

In our best efforts to protect your personal protected health information we want to ensure our HIPAA privacy practices, are readily available to all patients. I acknowledge I have received or reviewed a copy of this office's Notice of Privacy Practices and am also aware that the notice is posted in the waiting area for review.

Print Name:_____

Signature:_____

Date:_____

Office Financial Policy for Crown Hill Dentistry

I request that payment of authorized insurance benefits be made on my behalf to Brittany D Gooding DDS PC dba Crown Hill Dentistry "office", for any services furnished me by that dentist/supplier. I authorize any holder of medical information about me to release to my insurance any information needed to determine these benefits or the benefits payable for related services. I agree that in consideration of the services to be rendered to the below named patient, we are obligating ourselves to pay this account in full. I also understand that the office does not provide Medicare dental services and that Medicare may not be billed for any services performed here and that these procedures will be provided at a fee for service rate from the treating doctor. Should the account be referred to another agent for collections, the undersigned shall pay all reasonable fees, court costs, or collection expenses of 40% in addition to outstanding balance, and risk cancellation as patients for non-payment of the account or the filing of bankruptcy. I also understand that upon a 2nd failed appointment to my or my family's account without warning to the office that I may be subject to a $35 failed appointment fee if prior notice is not given to the office before the stated appointment time.

I have received and read the Brittany D Gooding DDS PC dba Crown Hill Dentistry Notice of Privacy Act:

Signed Signature:_____

Printed Signature:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)