Eric Crawford DDS Family Dentistry

office@ericcrawforddentist.com

www.ericcrawforddentist.com

6017 SW. 45th Street • Amarillo, TX 79109

(806)353-1502

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Social Security Number: _____

Drivers License #: _____

Whom may we thank for referring you to our practice? Please check the box that applies and enter the name in the space provided. *

☐ Yellow Book Phonebook ☐ User Friendly Phonebook ☐ AT&T Phonebook ☐ yellowbook.com ☐ Google

☐ Yelp ☐ Facebook ☐ WTAMU ☐ Other (name below):

Did you find our reviews helpful in making your decision to contact our office? * ◯ Yes ◯ No

Name of person, office, or other source referring you to our practice:

_____

_____

Emergency Contact/Emergency Contact Phone Number:

_____

_____

Preferred Pharmacy

Enter Name and Address

_____

_____

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ___-___ (Zip Code)

Dental Insurance Information

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ___-___ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ___-___ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ___-___ (Zip Code)

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1??% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent, or guardian (responsible party):

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

_____

Response Date: _____

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Dental Information

Do you have or have you had any of the following?

- ☐ Bleeding gums when brushing or flossing
- ☐ Food or floss catch between your teeth
- ☐ Periodontal (gum) treatments
- ☐ Problems associated with previous dental treatment
- ☐ Earaches or neck pain
- ☐ Brux or grind teeth
- ☐ Wear dentures or partials
- ☐ Had a serious injury to your head or mouth
- ☐ Sensitivity to cold, hot, sweets or pressure
- ☐ Dry mouth
- ☐ Orthodontic (braces) treatments
- ☐ Current dental pain or discomfort
- ☐ Clicking, popping, or discomfort in the jaw
- ☐ Sores or ulcers in mouth
- ☐ Participate in active recreational activities

Date of your last dental exam: _____

What was done at that time?

_____

_____

Date of last dental x-rays? _____

What is the reason for your dental visit today?

_____

_____

How do you feel about your smile?

_____

_____

Medical Information

Please list all physicians you currently see or have seen. ◯ Yes ◯ No

Physician Name:

_____

_____

Are you in good health? ◯ Yes ◯ No

Has there been any change in your general health within the past year? ◯ Yes ◯ No

If yes, what condition is being treated?

_____

_____

Date of last physical exam: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ◯ Yes ◯ No

If yes, what was the illness or problem?

_____

_____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ◯ Yes ◯ No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ◯ Yes ◯ No

Joint replacement date: _____

If yes, have you had any complications?

_____

_____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?

◯ Yes ◯ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal compliations resulting from Paget's disease, multiple myeloma or metastatic cancer?

◯ Yes ◯ No

Date treatment began: _____

Do you use controlled substances (drugs)? ◯ Yes ◯ No

Do you use tobacco (smoking, snuff, chew, bidis)? ◯ Yes ◯ No

If so, how interested are you in stopping?

◯ Very ◯ Somewhat ◯ Not interested

Do you drink alcoholic beverages? ◯ Yes ◯ No

If yes, how much alcohol did you drink in the last 24 hours? _____

Women Only

Are you pregnant? ◯ Yes ◯ No

Number of weeks: _____

Do any of the following apply?

☐ Taking birth control or hormonal replacement ☐ Nursing

Allergies - Are you allergic to or have you had a reaction to:

- ☐ Local anesthetics
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Metals
- ☐ Other
- ☐ Aspirin
- ☐ Sulfa drugs
- ☐ Latex (rubber)
- ☐ Penicillin or other antibiotics
- ☐ Codeine or other narcotics
- ☐ Iodine

Allergies - To all yes responses, specify type of reaction.

_____

_____

Please mark (X) your response to indicate if you have had any of the following diseases or problems.

- ☐ Atificial (prosthetic) heart valve
- ☐ Congenital heart disease (CHD)
- ☐ Previous infective endocarditis
- ☐ Unrepaired (completely) in the last 6 months
- ☐ Damaged valves in transplanted heart
- ☐ Repaired CHD with residual defects

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Do any of the following apply?

- ☐ *Pre-Med
- ☐ Angina
- ☐ Artificial Heart Val
- ☐ Bisphosphonates
- ☐ Cancer
- ☐ COPD
- ☐ Drug/Alcohol Addict
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Hepatitis B
- ☐ Jaundice
- ☐ Lung Disease
- ☐ Mitral Valve Prolaps
- ☐ Parkinsons
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Systemic lupus eryth
- ☐ Ulcers
- ☐ Abnormal bleeding
- ☐ Anticoagulants
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Cardiovascular disea
- ☐ Damaged heart valves
- ☐ Eating disorder
- ☐ Fainting
- ☐ Head Injuries
- ☐ Heart Trouble
- ☐ Hepatitis C
- ☐ Kidney Disease
- ☐ Malnutrition
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Rheumatism
- ☐ Stomach Problems
- ☐ Thyroid Disease
- ☐ Venereal Disease
- ☐ AIDS/HIV infection
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Emphysema
- ☐ G.G. Reflux/heartbur
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Osteoporosis
- ☐ Renal Dialysis
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Arthritis
- ☐ Autoimmune disease
- ☐ Bronchitis
- ☐ Congestive heart fai
- ☐ Dizziness
- ☐ Epilepsy/Seizures
- ☐ Gastointestinal dise
- ☐ Heart Disease
- ☐ Hepatitis A
- ☐ Irregular Heartbeat
- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Scarlet Fever
- ☐ Swollen Glands/Neck
- ☐ Tumors

Neurological disorders ◯ Yes ◯ No

If yes, specify:

_____

_____

Mental health disorders ◯ Yes ◯ No

Specify:

_____

_____

Recurrent Infections ◯ Yes ◯ No

Type of infection:

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment ◯ Yes ◯ No

Do you have any disease, condition, or problem not listed above that you think I should know about? ◯ Yes ◯ No

Please explain:

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that Dr. Crawford and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Crawford, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature _____ **Date** _____

I authorize full disclosure of my medical records to the following person:

Response Date: _____

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Office Insurance and Payment Policy

Full payment is expected when treatment is performed. As a convenience to you, our office will submit charges for services to your dental insurance company, but we consider you responsible for the account. We require all patients with dental insurance to pay a percentage of the cost of their treatment as a down payment. Please feel free to speak to one of our office staff if you have any questions regarding this matter.

For your convenience we accept Cash, Check, Visa, Mastercard, Discover, American Express and CareCredit.

We also work with Amarillo National Bank to provide financing.

Dental insurance is not designed to cover the entire fee, nor every service. It pays a designated amount based on premiums you pay and the coverage your employer has contracted for. Our treatment recommendations are not based on whether or not you have insurance, nor are treatments altered to fit into your insurance benefits. We have a great deal of experience with dental insurance and will be as helpful as we can.

Any disputes you have with the dental insurance company will ultimately be up to you or your employer to resolve.

We do not file medical insurance. We do not have medical codes. If your policy required procedures to be filed under medical coverage, you will be responsible for payment to this office in full and filing the medical claims yourself.

Collections. If an account is delinquent for more than 120 days, it will be turned over to a third party for collection. The collection fees will be added to the already owed amount.

Patient Signature or Legal Guardian

Signature _____ **Date** _____

Response Date: _____

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Patient Name: _____ _____ ____ _____

Last First MI Preferred Name

We value you as our patient and need your cooperation with keeping appointments so that we can provide you with the best care possible, in a timely manner. Missing or late canceling an appointment means we are unable to offer this appointment time to another patient.

Our Policy Requires:

Appointment Confirmation:
Please confirm your appointment when contacted by our office. If we cannot confirm your appointment we will make that time available on our appointment schedule. This will be considered a missed appointment.
Initial: *

_____

Timely Cancellations:
If you need to cancel or reschedule your appointment, please give us at least a 24 hour notice. Cancellations made with less than a 24 hour notice will be considered a missed appointment.
Initial: *

_____

On Time Arrivals:
We value your time and pride ourselves in not having patients spend a long amount of time waiting for their scheduled appointment. Please help us maintain our schedule by arriving on time for your appointment.
If you are more than 20 minutes late to your appointment, we will cancel it. This will be considered a missed appointment.
Initial: *

_____

Compliance:
Patients are only allowed ONE missed appointment in a 12 month period. After the second missed appointment you may call our office to see if we have a "same day appointment" available or you may put down a deposit for your requested time. This deposit will be credited to treatment completed at your appointment.
Initial: *

_____

Your help in keeping your appointment enables us to provide better and timelier care for all our patients.

Signature of patient, parent, or guardian (responsible party):

Signature _____ **Date** _____

Response Date: _____

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HIPAA Privacy Act

With your consent, the practice of Eric Crawford DDS Family Dentistry is permitted by federal privacy laws to make use and disclosure of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

I have been informed that I may review Eric Crawford DDS Family Dentistry's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and to enact new provisions regarding the protected health information we maintain. If our privacy practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by going to our website www.ericcrawforddentist.com, calling
(806)353-1502 and requesting a copy or by visiting our office and picking up a copy.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I, _____, hereby acknowledge that I have been given the opportunity to receive a copy of Eric Crawford DDS Family Dentistry's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

For verification purposes, we require a copy of your drivers license or a form of identification with a photograph.

Please sign and date below:

Signature _____ **Date** _____

If you signed this form and are the parent or legal guardian, please indicate: _____

I authorize full disclosure of my medical records to the following person:

_____

_____

_____

Response Date: _____