ROBERT L. CROSBY, D.M.D., P.C.

Patient Information

Patient Name:_____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child Email Address_____

Social Security #:_____ Birth Date:_____

Phone (Home):_____ (Work):_____(Cellular):_____ Best time to call:_____

Address:_____
Street Apartment #

_____
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS, HIV Positive
☐ Alcohol / Drug Abuse
☐ Anemia
☐ Angina
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer / Chemotherapy
☐ Diabetes
☐ Osteoporosis

☐ Epilepsy / Seizures
☐ Excessive Bleeding
☐ Fainting Spells
☐ Glaucoma
☐ Artificial Heart Valve
☐ Pacemaker
☐ Heart Disease, Attack
☐ Congenital Heart Defect
☐ Bacterial Endocarditis
☐ Heart Murmur
☐ Rheumatic Fever

☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Psychiatric Treatment
☐ Nervous Disorders
☐ Organ Transplant
☐ Pregnancy
Due Date:_____
☐ Radiation Treatment
☐ Respiratory Problems

☐ Sinus Problems
☐ Stomach Problems / Ulcers
☐ Stroke
☐ Tuberculosis
☐ Thyroid Disease
☐ Latex Allergy
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Local Anesthetic Allergy
☐ Other Allergy
_____
_____

☐ Other Health Problems:_____

• Prescribed Medications:_____

_____

• Do you take blood thinners: ☐ Yes ☐ No

• Has your doctor told you to premedicate prior to dental treatment? ☐ Yes ☐ No

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:_____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain:_____

• Are you now under the care of a physician? ☐ Yes ☐ No Physician:_____
If yes, please explain:_____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No Physician:_____
If yes, please explain:_____

• Name of the nearest relative not living with you:_____ Phone:_____
Relationship to this person:_____

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change to my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Website ☐ Work ☐ Other

Name of person or office referring you to our practice:_____