

# 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:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> AIDS, HIV Positive    | <input type="checkbox"/> Epilepsy / Seizures     | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Sinus Problems            |
| <input type="checkbox"/> Alcohol / Drug Abuse  | <input type="checkbox"/> Excessive Bleeding      | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Stomach Problems / Ulcers |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Fainting Spells         | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Angina                | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Thyroid Disease           |
| <input type="checkbox"/> Artificial Joints     | <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Nervous Disorders     | <input type="checkbox"/> Latex Allergy             |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Heart Disease, Attack   | <input type="checkbox"/> Organ Transplant      | <input type="checkbox"/> Codeine Allergy           |
| <input type="checkbox"/> Blood Disease         | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Pregnancy             | <input type="checkbox"/> Penicillin Allergy        |
| <input type="checkbox"/> Cancer / Chemotherapy | <input type="checkbox"/> Bacterial Endocarditis  | Due Date: _____                                | <input type="checkbox"/> Local Anesthetic Allergy  |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Other Allergy             |
| <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Respiratory Problems  | _____  |
- 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.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

## 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: \_\_\_\_\_