Richard J. Croft, D.D.S
Practice Dedicated to Excellence

7170 E. McDonald Dr #1
Scottsdale, Az 85253
(480) 946-3333

PERSONAL INFORMATION **Date**________________________

Name:____SS#____________________________

Address:____
Street City Zip
Home Phone:______________________Work Phone_________________Cell Phone:___________________
Birth date:__________________Sex______Martial Status_____Spouse Name:________________________
Employer:_____________________________________Occupation:________________________________

Whom may we thank for referring you to our Practice?____

PERSON RESPONSIBLE FOR ACCOUNT

Name:______________________________________Relationship:___________SS#_____________________

Address:____
Street City Zip
Home Phone:____________________Work Phone:________________Cell Phone:_______________________

MEDICAL HISTORY:

Date of last dental visit:___________________________Reason for visit:_______________________________

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

_Aids/HIV	_Excessive Bleeding	_ Liver Disease	_Stomach Problems
_Allergies____________	_Fainting	_Mental Disorders	_Tuberculosis
____________	_Glaucoma	_Nervous Disorders	_Tumors
_ Anemia	_Growths	_Pacemaker	_Ulcers
_Arthritis	_Hay Fever	_Pregnancy	_Venereal Disease
_Artificial Joints	_Head Injuries	Date Due_________	**_ Codeine Allergy**
_ Asthma	**_Heart Disease**	_Radiation Treatment	**_Penicillin Allergy**
_ Blood Disease	**_Heart Murmur**	_Respiratory Problems	**_ EpinephrineAllergy**
_Cancer	_Hepatitis	**_Rheumatic Fever**	**_ Latex Allergy**
_Diabetes	_High Blood Pressure	_Stroke	
_ Dizziness	_Jaundice	_Sinus Problems	
_Epilepsy	_Kidney Disease		

Are you allergic to any metals? If yes, what?__________________________Have you ever had a skin rash or other reaction to metal jewelry? If yes, to what?____

Are you now under the care of a physician? Yes______ No_______ If Yes, forwhat?_________________________

Name of your physician____Phone_________________________

Do you need to pre-medicate before dental treatment? Yes_____ No______ Don't know______________________

Are you currently taking any medication or drugs? If yes, what?____
____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes______No______
If yes, Please explain____

Person to contact in case of emergency other than relative:

Name_________________________________Address____________________________Phone______________

How would you describe the condition of your teeth and gums? Good____ Fair _____ Poor_____

If you could wave a magic wand, and change anything you could about the appearance of your teeth, what would you like to do?____

If you could easily and safely whiten your teeth, would you be interested? Yes________No__________

How often do you brush your teeth?__________________Floss your teeth?_______________________

Do your gums bleed when you brush or floss? Yes____________ No____________

Insurance Info

Name of insured____Is insured patient?_____________
Last First Mi
Insured's Birthdate___________________________ID #__________________________Group#______________

Insured's Address____
Street City Zip
Insured's Employer _________________________________Address_____________________________________
Street
____Phone __________________________________
City State Zip

Patient's relationship to insured: Self_____ Spouse______ Child______ Other_______

Insurance Plan Name and Address ____

____

CONSENT FOR SERVICES

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will gladly prepare and submit the necessary insurance forms, however this office cannot render services on the assumption that our charges will be paid by an insurance company.

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

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

I understand that all of the above information is correct to the best of my knowledge and that it will be held in the strictest confidence and only be used to improve communications between the Doctor and myself. I give the Doctor or his staff my permission to use any photos taken for lecturing or educational purposes. I also authorize assignment of insurance benefits to this dental office if applicable.

____
Signature of patient, parent or guardian

Relationship to patient____________________Date__________________

____
Signature of guarantor of payment/responsible party

Relationship to patient____________________Date___________________

PATIENT INFORMATION

WE LIKE TO KNOW SOMETHING ABOUT EACH OF OUR PATIENTS. TO HELP US GET TO KNOW YOU BETTER, WILL YOU PLEASE FILL IN THE FOLLOWING INFORMATION.

NAME____

BIRTHPLACE____

WHERE DID YOU GROW UP?____

WHERE YOU HAVE LIVED AS AN ADULT?_____________________________________

____

CHILDREN AND THEIR
AGES____

____

EDUCATIONAL BACKGROUND____

VOCATION____

HOBBIES____

SPECIAL INTERESTS OR ACTIVITIES____

ANYTHING SPECIAL YOU WOULD LIKE US TO
KNOW?____

____