

**CREATIVE DENTAL CONCEPTS OF CNY
NEW PATIENT INFORMATION FORM**

PATIENT: _____ DATE: _____
 (First) (Middle) (Last)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PREFERRED NAME: _____ DOB: _____

MARITAL: S - M - D - W SEX: M/F SOCIAL SECURITY#: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

EMPLOYER/SCHOOL: _____ OCCUPATION: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

OUR PRACTICE DOES NOT PARTICIPATE WITH YOUR DENTAL PLAN

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER'S NAME: _____ RELATION TO PATIENT: _____

SUBSCRIBER'S COMPLETE ADDRESS: _____

SUBSCRIBER'S EMPLOYER: _____ SUBSCRIBER'S DOB: _____

INSURANCE COMPANY: _____

INSURANCE COMPANY'S ADDRESS: _____

SS #/ID #: _____ GROUP #: _____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER'S NAME: _____ RELATION TO PATIENT: _____

SUBSCRIBER'S COMPLETE ADDRESS: _____

SUBSCRIBER'S EMPLOYER: _____ SUBSCRIBER'S DOB: _____

INSURANCE COMPANY: _____

INSURANCE COMPANY'S ADDRESS: _____

SS #/ID #: _____ GROUP #: _____

RESPONSIBLE PARTY

NAME AND COMPLETE ADDRESS: _____

SIGNATURE: _____ HOME/CELL PHONE: _____ DATE: _____

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

City State Zip:

Email:

Home Phone:

Work Phone:

Cell Phone:

Birth Date:

Social Security No.:

Marital Status:

Primary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

Secondary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

Physician Name:

Physician Phone:

Pharmacy:

Pharmacy Phone:

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N

Are you taking Birth Control Pills?

Are you pregnant?

If Yes, # of weeks

Are you nursing?

Please answer the following:

Y N

Do you smoke or use tobacco?

Height:

For Office Use Only

BP

Heart Rate:

Weight:

Y	N	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	PreMed
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Cancer- Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells
<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma

Y	N	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems

Y	N	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily

Y	N	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
Other		
<hr/>		
<hr/>		
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Medications:

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Y N

Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

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Notes:

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Signature: _____
(If Under 18, Parent or Guardian Signature Required)

Date: _____

CREATIVE DENTAL CONCEPTS OF CNY

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Donald Crumb, DDS

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(315) 475-6651 fax

Email: care@cerecuse.com

Request for Dental Records

It is requested that the following office:

Please forward requested information for the following patient(s).

Name

DOB

- Written Records
- Most Recent Bitewing Radiographs
- All Periapical Radiographs
- Panorex and /or FMX

(IF YOU ARE DIGITAL - Please email the patient(s) records to our office in a JPG file format)

Parent/Guardian/Patient Signature

Date

Thank you kindly for your prompt attention.