

# JEFFREY CROSS, D.D.S., P.A.

604 Solarex Court, Suite 200

Frederick, Md. 21703

(301) 662-0300

SS# \_\_\_\_\_

## PATIENT INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_

Last Name

First Name

Initial

Check appropriate box:  minor  single  married  divorced  separated  widowed

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Nickname \_\_\_\_\_

Home Address \_\_\_\_\_

Street

City

State

Zip

Mailing Address \_\_\_\_\_

Street

City

State

Zip

Employer \_\_\_\_\_

Business Address \_\_\_\_\_

Street

City

State

Zip

Person financially responsible \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

### PRIMARY

Name of Insured \_\_\_\_\_

Birthdate \_\_\_\_\_

Social Security Number \_\_\_\_\_

Drivers License Number \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Name of Employer \_\_\_\_\_

Work Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How much is your deductible? \_\_\_\_\_

Maximum annual benefit? \_\_\_\_\_

### SECONDARY

Name of insured \_\_\_\_\_

Birthdate \_\_\_\_\_

Social Security Number \_\_\_\_\_

Drivers License Number \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Name of Employer \_\_\_\_\_

Work Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How much is your deductible? \_\_\_\_\_

Maximum annual benefit? \_\_\_\_\_

## EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## DENTAL HISTORY

Reason for Today's Visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

Address \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

Check (✓) if you have had problems with any of the following:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Loose teeth or broken fillings                | <input type="checkbox"/> Snoring                       |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Oral habits (fingernail biting, cheek biting) | <input type="checkbox"/> Sores or growths in the mouth |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment                         | <input type="checkbox"/> Unfavorable dental experience |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to hot or cold                    | <input type="checkbox"/> Unpleasant taste              |
| <input type="checkbox"/> Grinding teeth                | <input type="checkbox"/> Sensitivity to sweets or pressure             |  |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

Do you smoke? \_\_\_\_\_