Greg A. Crawford, D.D.S.
4116 East State Blvd. ● Fort Wayne, IN 46815 ● Phone: (260) 482-3759

Welcome and thank you for selecting us. We look forward to working with you in maintaining your dental health.

To help us meet all your healthcare needs, please fill out this form in ink.
If you have any questions or need assistance, we will be happy to help you.

Patient Information:

Date_____Home Phone (_____)_____Cell Phone (_____)_____Work Phone (_____)_____

Name_____Birthdate_____ ☐ Male ☐ Female

Address _____City_____ State_____ Zip_____

Marital Status _____SSN_____Email_____

Employer or College (if student)_____Occupation_____

In case of emergency, please contact _____ Phone (_____)_____

Whom may we thank for referring you?_____

Responsible Party: Responsible party information is the same as patient information

Person responsible for account_____ Phone (_____)_____Relationship to patient_____

Address_____ City_____ State_____ Zip_____

Responsible Person employed by_____Occupation_____

Business Address_____Business Phone (_____)_____

Dental Insurance: (Please provide copy of dental insurance card)

Name of Policy Holder_____Relationship to patient_____

Policy Holder Birthdate_____Policy Holder SSN or Ins ID_____Group #_____

Policy Holder Employed by_____Employer Address_____

Insurance Company_____Claims Mailing Address_____

Do you have secondary dental insurance coverage? ☐ Yes ☐ No

Dental History:

Reason for Today's visit_____Date of last dental care_____ Date of most recent dental x-rays_____

Check if you have a history of, or are currently experiencing, any of the following:

☐ Bad Breath	☐ Prolonged bleeding following extractions	☐ Orthodontic treatment
☐ Bleeding Gums	☐ Sores, lumps or growths in the mouth	☐ Periodontal treatment
☐ Food packing between teeth	☐ Sensitivity or pain in any of your teeth	☐ Not satisfied with appearance of teeth

Would you like to improve the appearance of your smile?_____

Medical History:

Name of Physician_____Date of last visit_____

Are you currently under medical treatment? ☐ Yes ☐ No If yes, please explain: _____

Have you had chemotherapy, Zometa, Aredia or Bonefos? ☐ Yes ☐ No If yes, please describe_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check if you have or have previously had any of the following:

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS/HIV	☐	☐	Cardiac Pacemaker	☐	☐	Hepatitis/Jaundice
☐	☐	Artificial Joints	☐	☐	Diabetes	☐	☐	High Blood Pressure
☐	☐	Asthma	☐	☐	Epilepsy/Convulsions	☐	☐	Stroke
☐	☐	Blood Disease	☐	☐	Fainting//Seizures	☐	☐	Tobacco Habit
☐	☐	Cancer	☐	☐	Heart Problems/Heart Attack	☐	☐	Tuberculosis

Acknowledgement of receipt of notice of Privacy Practices:

I _____have been made aware of this office's privacy practices.

Signature of Patient or Responsible Party_____ Date_____

For those patients with insurance coverage:

1. In consideration of Dr. Crawford rendering dental services to me, or a member of my family for whom I am financially responsible, I hereby assign to Dr. Crawford all insurance which I have a right to in regard to charges incurred in this office.

2. This assignment does not constitute payment for indebtedness and does not relieve the undersigned from liability for unpaid indebtedness.

3. In the event the insurance carrier pays benefits directly to me (instead of to Dr. Crawford as I hereby request) for services performed, I agree that I will immediately deliver all such benefits to Dr. Crawford up to the amount of my indebtedness.

For those patients who do not have insurance coverage:

If I do not have insurance coverage, I understand that I am financially responsible for all bills incurred during my treatment.

Authorization for release of information:

Dr. Crawford is hereby authorized to furnish such professional information as may be necessary for the completion of my insurance claim from the dental records compiled during my treatment. Dr. Crawford is hereby released from all legal liability that may arise from the release of the information requested.

I (we) further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made at discharge, or within 30 days of discharge, to pay for in-office processing fees. I (we) further agree to pay collection costs and reasonable attorney fees if this account is placed in the hands of a collection agency or attorney.

☐ I have read the above and foregoing and fully understand the terms thereof.

Patient's Name _____

Signature of Patient or Responsible Party_____ Date_____

Witness_____Date_____