

TOWNCREST DENTAL OFFICES, P.C.

1008 William Street • Iowa City, Iowa 52240 • (319) 337-2114

Dr. Jennifer R.M. Ballard, DDS

Dr. Curt C. Maas, DDS

Dr. Jay R. Davidson, DDS

In order to help us render the proper dental services to you, please be kind enough to answer the following confidential questions. Please note the space for remarks for any answers that require clarification or any other information you think we should have. Thank you for your cooperation. Welcome to our office!

Date: _____ Social Security #: _____

Preferred title (Dr., Mr., Mrs., Ms., Miss) - please circle one.

Patient's name: _____ Date of birth: ____/____/____
(first) (middle) (last) mo. day yr.

Mailing Address: _____
(street) (apartment)

(city) (state) (zip)

Phone: Day: _____ Evening: _____ E-Mail: _____
Cell: _____ (If you would like to be contacted by e-mail for your appt., please provide email.)

Occupation: _____ Employer: _____

Business address: _____

Business phone: (____) _____ May we call you at your business? _____

Spouse's name: _____

Spouse's occupation: _____ Employer: _____

If minor, person to contact: _____ Social Security #: _____

Phone: Day: _____ Evening: _____

Party responsible for payment of account: _____ Soc. Sec. # _____

Phone: Day: _____ Evening: _____ E-mail: _____

Mailing Address: _____
(street) (apartment)

(city) (state) (zip)

Relationship to patient: _____ Is party aware of this visit? _____

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Whom may we thank for referring you? \_\_\_\_\_ yellow pages  referral  website

Reason for this visit: \_\_\_\_\_  
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DENTAL INSURANCE INFORMATION

Name of primary insurance company: _____

Address: _____

Policy, plan, or group number: _____

Name, date of birth, & social security number of person carrying this insurance:

Name: _____ Date of birth: ____/____/____ SS#: _____

Insured's relationship to patient: _____

Name & address of insured's employer: _____

Is the patient a student? _____ School: _____ City: _____

Please provide complete and accurate insurance information.
I understand a minimum of \$2.00 or 1.5% per month (18 APR) may be applied to all overdue accounts. If my insurance company does not pay in full within 90 days, Towncrest Dental may ask me to pay my balance with cash, check, Mastercard, or Visa. Towncrest Dental does their best to provide the information regarding my visits to my insurance company as a service to me. It is (my) the patient's responsibility to give Towncrest Dental Office the correct insurance information and to encourage my insurance company to process within 90 days. There may also be a missed appointment fee of \$35.00 charged to your account if we do not have 24 hour notice for a change in your appointment plans. I understand that as a patient or guardian I am also responsible for all legal and/or collection costs when necessary.

X _____
PATIENT SIGNATURE (parent's signature if patient is under 18 years old)

MEDICAL HISTORY

Name & address of physician: _____
 Approximate date of last complete physical: _____
 Were there any significant findings? _____

PLEASE ANSWER WITH A CHECK MARK IN THE APPROPRIATE PLACE YES NO

Are you presently under the care of the physician?

For what reason? _____

Are you taking any medication now?

For what purpose? _____

Medication name(s): _____

If female, are you taking birth control pills?

Have you been hospitalized in the last two years?

Do you have any artificial joints, implants, heart valves, etc.?

Do you have any history of drug or alcohol abuse?

Do you use tobacco products?

HAVE YOU EVER BEEN DIAGNOSED AS HAVING:

	YES	NO		YES	NO
Heart disease/heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores or fever blisters?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	Could you be pregnant now?	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart lesion?	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been premedicated for an appt.?	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what medication? _____			Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or obstructive lung disease?	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
Are you subject to prolonged bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to:		
Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin?	<input type="checkbox"/>	<input type="checkbox"/>
HIV or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	Codeine?	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Latex?	<input type="checkbox"/>	<input type="checkbox"/>
type _____			Other medication?	<input type="checkbox"/>	<input type="checkbox"/>
Ever receive radiation therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Type(s) _____		
Persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>			

DENTAL HISTORY

	YES	NO		YES	NO
Approximate date of last dental visit _____			Do you ever have pain near the ear?	<input type="checkbox"/>	<input type="checkbox"/>
Were x-rays taken?	<input type="checkbox"/>	<input type="checkbox"/>	Do your jaws ever feel tired?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think your oral hygiene is adequate?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your jaws		
Would you like help improving?	<input type="checkbox"/>	<input type="checkbox"/>	while sleeping or during the day?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been instructed on the proper			Have you ever had novocaine?	<input type="checkbox"/>	<input type="checkbox"/>
home care of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	If so, any adverse reactions?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed while brushing?	<input type="checkbox"/>	<input type="checkbox"/>	Are you apprehensive about		
Do your gums bleed while flossing?	<input type="checkbox"/>	<input type="checkbox"/>	having dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your			Have you ever had nitrous oxide		
mouth due to pain?	<input type="checkbox"/>	<input type="checkbox"/>	(happy gas) at the dentist?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what part? _____			Are you satisfied with the health and		
Do you feel twinges of pain when your teeth			appearance of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
come in contact with:			If not, explain _____		
Cold foods?	<input type="checkbox"/>	<input type="checkbox"/>	Have you worn braces?	<input type="checkbox"/>	<input type="checkbox"/>
Hot foods?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had root canal therapy?	<input type="checkbox"/>	<input type="checkbox"/>
Sweet foods?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had all your wisdom teeth		
Sour foods?	<input type="checkbox"/>	<input type="checkbox"/>	removed?	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew only on one side of			Have you had periodontal therapy?	<input type="checkbox"/>	<input type="checkbox"/>
your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any teeth bothering you now?	<input type="checkbox"/>	<input type="checkbox"/>
If so, explain _____			If so, explain _____		
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			

Name of previous dentist: _____
 What things about your past dental experiences have you disliked most? _____

What things about your past dental experiences have you liked most? _____

Please add anything else you feel is important _____

I understand that I am responsible to inform Towncrest Dental of any changes in my health and any changes in my dental insurance (if applicable). Thank you for your cooperation!

X _____
 PATIENT SIGNATURE (parent's signature if patient is under 18 years old)