Cori K. Crider, DDS

Cosmetic & Family Dentistry in Ypsilanti

WELCOME TO OUR PRACTICE

On behalf of the entire team at our office, let us welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequaled advanced training in cosmetic and reconstructive dentistry we have received.

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed Personal Information Sheet and Medical and Dental History questionnaire that should be filled out prior to your first appointment with us.

Be sure to visit our website at www.CoriCriderDDS.com. We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

Cori K. Crider, DDS

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2444 Packard Road • Ypsilanti, MI 48197 • (734) 572-4428

www.CoriCriderDDS.com

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PATIENT REGISTRATION

Welcome to our office. Please be kind enough to answer the following questions. Thank you so much for being our guest!

Name (Last) (First) (Middle) Date of Birth Sex (M F) Marital Status (S M D W) Social Security Number

How would you like to be addressed? Email Address Cell Phone Number

Home Address (Street) (City) (State) (ZIP Code) Home Phone Number

Name of Employer Occupation Driver's License Number

Business Address (Street) (City) (State) (ZIP Code) Business Phone Number

PERSON RESPONSIBLE FOR ACCOUNT

Who is responsible for account? self spouse parent/guardian other

(Please fill in the following information if the person responsible is different from self.)

Name (Last) (First) (Middle) Social Security Number

Home Address (Street) (City) (State) (ZIP Code) Home Phone Number

Name of Employer Occupation Business Phone Number

INSURANCE INFORMATION

Insured Member (Last) (First) (Middle) Relationship SSN Date of Birth

Name of Employer Occupation Business Phone Number

Business Address (Street) (City) (State) (ZIP Code) Dental Insurance Co.

Group Number _____ ID Number _____

What are your hobbies? Special interests? _____

How did you hear of our office? _____

If patient was assisted with this form, enter name of person assisting:

_____ _____

Print name Sign name Date

_____ _____

Signature of patient Date

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MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

General health (please check): EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑ Name of physician _____
Physician's Address _____ Telephone Number _____ Date of Last Physical _____
Are you now under the care of a physician? Yes ❑ No ❑
Are you pregnant or do you think you may be pregnant? Yes ❑ No ❑ If yes, expected delivery date: _____
Are you nursing? Yes ❑ No ❑ Are you taking birth control pills? Yes ❑ No ❑
Do you smoke? Yes ❑ No ❑ If yes, how much? _____
Are you taking any medication now? Yes ❑ No ❑ If yes, names of medications and problems for which they are taken:
Medication 1) _____ Taken for _____ 3) _____ Taken For _____
2) _____ Taken for _____ 4) _____ Taken For _____

Do you use tobacco? Yes ❑ No ❑
Have you ever required a blood transfusion? Yes ❑ No ❑
Do you or have you used controlled substances? Yes ❑ No ❑
Have you ever taken Fen-Phen or Redux? Yes ❑ No ❑
Are you wearing contact lenses? Yes ❑ No ❑
Do you bruise easily? Yes ❑ No ❑

Have you ever had (please check-mark appropriate boxes):

Abnormal blood pressure High ❑ Low ❑ No ❑
AIDS/HIV Yes ❑ No ❑
Anemia Yes ❑ No ❑
Arthritis Yes ❑ No ❑
Asthma or hay fever Yes ❑ No ❑
Allergies Yes ❑ No ❑
Back problems Yes ❑ No ❑
Cancer Yes ❑ No ❑
Chemical dependency Yes ❑ No ❑
Cold sores/Fever blisters Yes ❑ No ❑
Common cold Yes ❑ No ❑
Congenital heart lesions Yes ❑ No ❑
Diabetes Yes ❑ No ❑
Drastic weight loss Yes ❑ No ❑
Eating disorders Yes ❑ No ❑
Epilepsy/Seizures Yes ❑ No ❑
Excessive urination and/or thirst Yes ❑ No ❑
Fainting spells Yes ❑ No ❑
Glaucoma Yes ❑ No ❑
Heart disease Yes ❑ No ❑
Heart murmur Yes ❑ No ❑
Heart surgery Yes ❑ No ❑
Hepatitis Yes ❑ No ❑
Jaundice Yes ❑ No ❑
Joint replacement or implant Yes ❑ No ❑
Kidney trouble Yes ❑ No ❑
Mental health care Yes ❑ No ❑
Lymph node enlargement (swollen glands) Yes ❑ No ❑
Mitral valve prolapse Yes ❑ No ❑
Night sweats Yes ❑ No ❑
Pacemaker Yes ❑ No ❑
Persistent diarrhea Yes ❑ No ❑
Prolonged bleeding Yes ❑ No ❑
Rheumatic fever Yes ❑ No ❑
Sexually transmitted disease Yes ❑ No ❑
Sinus trouble Yes ❑ No ❑
Swollen ankles Yes ❑ No ❑
Stroke Yes ❑ No ❑
Thyroid problem Yes ❑ No ❑
Tuberculosis or lung disease Yes ❑ No ❑
Ulcers Yes ❑ No ❑
X-ray treatments for cancer Yes ❑ No ❑

If you have entered "yes" to any of the above, please explain: _____

Are you allergic to or have you had reactions to:

Local anesthetics like Novocaine Yes ❑ No ❑
Penicillin or other antibiotics Yes ❑ No ❑
Sulfa drugs Yes ❑ No ❑
Barbiturates, sedatives, or sleeping pills Yes ❑ No ❑
Codeine Yes ❑ No ❑
Aspirin Yes ❑ No ❑
Iodine Yes ❑ No ❑
Any metal (e.g. gold, nickel, etc.) Yes ❑ No ❑
Latex/Rubber Yes ❑ No ❑
Tylenol Yes ❑ No ❑

Other (please list) _____
Have you had any other serious illness, hospitalization, or accident? _____

*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms and release Dr. Crider to utilize any dental photographs for lecturing and educational purposes.

Signature: _____ Date: _____

DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____
What is your primary concern that you would like us to address first? _____
When would you like us to start treatment? _____
Have you ever had any serious problem associated with previous dental treatment or any dental emergencies?……Yes ❑ No ❑
If so, explain: _____
What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

_____

Do you have missing teeth?_____ If yes, have you had them replaced?_____
If you have had missing teeth replaced, are you happy with the results? _____
If not, would you like to learn about your options to replace them? _____
Do you ever feel (or have you ever been told) that you don't have fresh breath? _____
How often do you brush your teeth?_____ How often do you floss?_____ What type of brush do you use? Manual ❑ Powered ❑
Do you avoid brushing any part of your mouth because of pain? Yes ❑ No ❑ If yes, what part? _____
Which foods cause you twinges of pain: hot ❑ cold ❑ sweet ❑ sour ❑ none ❑ Do you lose fillings or break fillings?……..Yes ❑ No ❑
Do you chew on only one side of your mouth?……Yes ❑ No ❑ If yes, explain: _____
Do your gums feel tender or swollen?……..Yes ❑ No ❑ Do you usually have many cavities?…….Yes ❑ No ❑
Do you clench or grind your jaws while sleeping or during the day?……Yes ❑ No ❑ Do your jaws ever feel tired?……..Yes ❑ No ❑

We respect your right to choose the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the choices available to achieve long-term health and beauty for your existing natural teeth. Please check all that apply:

❑ I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and last for a long time.
❑ Spreading payments out over time may help me to achieve the excellent results I desire.
❑ Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.
❑ I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
❑ Although I am not interested in a plan for long-term dental health, I do desire an office who will treat teeth in need of immediate/ emergency attention, as well as keep me up to date on cleanings.

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____ Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = awesome)_____
Would you like to have whiter teeth? ❑ Yes ❑ No
What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____
Do you have any special occasions coming up? _____

If you had a magic wand, what, if anything, would you change about your smile? Please check off all that apply:

❑ Lighten all front teeth showing	❑ Rebuild fracture(s)	❑ Straighten rotation	❑ Eliminate dark or stained fillings
❑ Lighten single tooth	❑ Lengthen	❑ Straighten angulation	❑ Reduce gum showing in smile
❑ Close spaces between teeth	❑ Shorten	❑ Eliminate crowding	❑ Repair uneven edges

Please add anything you feel is important:_____

_____

At our office, though our focus is on appearance-related dentistry, our team also delivers routine general dental care. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.

Limited Patient Authorization for Disclosure of Protected Health Information

Patient Name: _____

SSN (last four digits) _____ Date of Birth: _____

Entity Requested to Release Information: Cori Crider DDS

Purpose of request (who will be authorized to receive information) – I authorize the entity listed above to disclose or provide protected health information, about me to the individual listed below.

Name: _____ Name: _____

Phone: _____Phone: _____

Email: _____Email: _____

Secure Communication- Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email if this is a concern to you.

Description of information to be disclosed- I authorize the practice to disclose the following protected health information about me to the person(s) identified above:

- Entire patient record; or, check only those items of the record to be disclosed:
- Office Notes
- Treatment
- Lab results
- X-rays
- Financial/Insurance report
- Appointment(s) history/future

This authorization will expire at the end of the calendar year, unless you specify an alternate date. You must submit a new authorization form after the calendar date to continue the authorization. Please list the date of expiration if other than the end of the calendar year _____

You have the right to terminate this authorization at any time by submitting a written request. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____ _____

Patient Signature or authorized representative signature Date