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)

~~~ PLEASE COMPLETE OTHER SIDE ~~~

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
Heart disease/heart attack?	☐	☐
Rheumatic fever?	☐	☐
Heart murmur?	☐	☐
Congenital heart lesion?	☐	☐
Have you ever been premedicated for an appt.?	☐	☐
If so, what medication? _____		
Asthma or obstructive lung disease?	☐	☐
Are you subject to prolonged bleeding?	☐	☐
Hepatitis?	☐	☐
HIV or AIDS?	☐	☐
Sexually transmitted disease?	☐	☐
Cancer? ..... type _____	☐	☐
Ever receive radiation therapy?	☐	☐
Persistent cough?	☐	☐

	YES	NO
Cold sores or fever blisters?	☐	☐
Could you be pregnant now?	☐	☐
Diabetes?	☐	☐
Ulcers?	☐	☐
Arthritis?	☐	☐
Stroke?	☐	☐
Glaucoma?	☐	☐
Are you allergic to:		
Penicillin?	☐	☐
Codeine?	☐	☐
Aspirin?	☐	☐
Latex?	☐	☐
Other medication?	☐	☐
Type(s) _____		

DENTAL HISTORY

	YES	NO
Approximate date of last dental visit _____		
Were x-rays taken?	☐	☐
Do you think your oral hygiene is adequate?	☐	☐
Would you like help improving?	☐	☐
Have you ever been instructed on the proper home care of your teeth?	☐	☐
Do your gums bleed while brushing?	☐	☐
Do your gums bleed while flossing?	☐	☐
Do you avoid brushing any part of your mouth due to pain?	☐	☐
If so, what part? _____		
Do you feel twinges of pain when your teeth come in contact with:		
Cold foods?	☐	☐
Hot foods?	☐	☐
Sweet foods?	☐	☐
Sour foods?	☐	☐
Do you chew only on one side of your mouth?	☐	☐
If so, explain _____		
Does food catch between your teeth?	☐	☐

	YES	NO
Do you ever have pain near the ear?	☐	☐
Do your jaws ever feel tired?	☐	☐
Do you clench or grind your jaws while sleeping or during the day?	☐	☐
Have you ever had novocaine?	☐	☐
If so, any adverse reactions?	☐	☐
Are you apprehensive about having dental treatment?	☐	☐
Have you ever had nitrous oxide (happy gas) at the dentist?	☐	☐
Are you satisfied with the health and appearance of your mouth?	☐	☐
If not, explain _____		
Have you worn braces?	☐	☐
Have you ever had root canal therapy?	☐	☐
Have you had all your wisdom teeth removed?	☐	☐
Have you had periodontal therapy?	☐	☐
Do you have any teeth bothering you now?	☐	☐
If so, explain _____		

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)