

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____
Address: _____ Address 2: _____
City: _____ State/ ZIP: _____
Cell Phone: _____ Other Phone: _____
Sex: Male Female Marital status: Single Married Divorced
Birthdate: _____ Age: _____ Social Security Number: _____
Email: _____
Business Name/ Employer: _____

Responsible Party (If different than above)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City: _____ State/ ZIP: _____
Cell Phone: _____ Other Phone: _____
Birthdate: _____ Age: _____ Social Security Number: _____

Primary Insurance Information

No insurance Patient is: Policy Holder Responsible Party

Employer: _____ Insurance Company: _____
ID Number or SSN: _____ Group Number: _____

Dental History

Reason for today's visit: _____

When were you last seen by a dentist? _____

Is there anything about your smile or teeth you would like to change? _____

How did you hear about our office? _____

Do you have any of the following symptoms in your mouth?

- Bad Breath Grinding Teeth Bleeding Gums Noise/ Pain in Jaw Broken Teeth
- Sores in Mouth Loose Teeth Sensitive to Sweets Sensitive to Biting Sensitive to Cold

Have you ever had periodontal (gum disease) treatment? If so, please explain: _____

Other dental problems/ concerns: _____

Medical History Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important inter-relationship with the dentistry you will receive. Thank you for answering the following questions. →

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you been recently hospitalized? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications or drugs? Yes No If yes, please list: _____

Do you take, or have you taken Phen-Fen or Redux? Yes No _____

Fosamax, Boniva, Actonel, or bisphosphonate use? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No _____

Do you use controlled substances? Yes No _____

(Women): Are you: Pregnant/Trying to get pregnant? Taking birth control pills? Nursing?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Local Anesthetic Acrylic Metal Latex Sulfa Drugs
 Other Please explain: _____

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

- | | | | |
|---|--|---|--|
| <input type="radio"/> AIDS/ HIV Positive | <input type="radio"/> Cortisone Medicine | <input type="radio"/> Hemophilia | <input type="radio"/> Radiation Treatments |
| <input type="radio"/> Alzheimer's | <input type="radio"/> Diabetes | <input type="radio"/> Hepatitis A | <input type="radio"/> Recent Weight Loss |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Drug Addiction | <input type="radio"/> Hepatitis B or C | <input type="radio"/> Renal Dialysis |
| <input type="radio"/> Anemia | <input type="radio"/> Easily Winded | <input type="radio"/> Herpes | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Angina | <input type="radio"/> Emphysema | <input type="radio"/> High Blood Pressure | <input type="radio"/> Rheumatism |
| <input type="radio"/> Arthritis/ Gout | <input type="radio"/> Epilepsy/ Seizures | <input type="radio"/> Hives or Rash | <input type="radio"/> Scarlet Fever |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Hypoglycemia | <input type="radio"/> Shingles |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Excessive Thirst | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Asthma | <input type="radio"/> Fainting/ Dizziness | <input type="radio"/> Kidney Problems | <input type="radio"/> Sinus Trouble |
| <input type="radio"/> Blood Disease | <input type="radio"/> Frequent Cough | <input type="radio"/> Leukemia | <input type="radio"/> Spina Bifida |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Frequent Diarrhea | <input type="radio"/> Liver Disease | <input type="radio"/> Stomach Disease |
| <input type="radio"/> Breathing Problem | <input type="radio"/> Frequent Headaches | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Stroke |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Genital Herpes | <input type="radio"/> Lung Disease | <input type="radio"/> Swelling of Limbs |
| <input type="radio"/> Cancer | <input type="radio"/> Glaucoma | <input type="radio"/> Mitral valve Prolapse | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Hay Fever | <input type="radio"/> Osteoporosis | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Chest Pains | <input type="radio"/> Heart Attack/ Failure | <input type="radio"/> Pain in Jaw Joints | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Cold Sores | <input type="radio"/> Heart Murmur | <input type="radio"/> Parathyroid Disease | <input type="radio"/> Tumors or Growths |
| <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Heart Pacemaker | <input type="radio"/> Psychiatric Care | <input type="radio"/> Ulcers |
| <input type="radio"/> Convulsions | <input type="radio"/> Heart Trouble/ Disease | | <input type="radio"/> Venereal Disease |
| | | | <input type="radio"/> Yellow Jaundice |

Any serious illness not listed above/comments: _____

Consent for Treatment & HIPAA

I give my consent for Dr. Beyer and his office staff to do a complete and thorough examination on the patient previously named, including any photographs, study models, needed radiographs, or other diagnostic aids. To the best of my knowledge, the information I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to notify Dr. Beyer of any future changes to the patient's medical status. I do hereby grant Dr. Beyer and his staff permission to perform any needed treatment(s). Furthermore, I have been offered a copy of Dr. Beyer's Privacy Policy.

_____ (Initial)

Requirement for Filing Insurance Claims

To precipitate the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I hereby authorize payment of insurance benefits directly to Dr. Beyer. I also authorize the use of this signature on all insurance submissions.

_____ (Initial)

Patient Signature: _____ Date: _____

Parent or Responsible Party (if different than above): _____

Relationship to Patient: _____