BEACH CITIES DENTAL GROUP

About You

Today's date: _____/_____/_____

E-mail Address: _____

Last Name: _____ First Name: _____MI __

◦Mr ◦Mrs ◦Ms ◦Dr Prefer to be called _____ ☐Male ☐Female

Birth Date: _____/_____/_____ Age: _____ SS#: _____-_____-_____

Home Address: _____Apt.____

City: _____ State: _____ Zip: _____

☐Single ☐Married ☐Partnered ☐Divorced/Separated ☐Widowed

Hm#: (_____) _____ Cell#: (_____) _____

Wk#: (_____) _____ Ext:_____ DL:_____

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

How long there? _____ Occupation: _____

Where & when is best time to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

☐Previous ☐Present Dentist: _____

Person Responsible for Account: _____

Spouse Information

His/Her Name: _____

Employer: _____

Birth Date: _____/_____/_____ Age: ____ SS#: _____-_____-_____

Wk#: (_____) _____ Ext: _____ DL:_____

Relative or Friend not living with you:

Name: _____

Relation: _____

Wk#: (_____) _____ Hm#:(_____)_____

Cell#: (_____) _____

Insurance

Primary Insurance:

Dental Coverage: ☐Yes ☐No

Insurance Co. Name: _____

Insurance Co. Address: _____

City: _____State:_____ Zip: _____

Insurance Co. Phone#: (_____) _____

Group# (Plan, Local or Policy#): _____

Insured's Name: _____Relation: _____

Insured's Birth date: _____/_____/_____ Insured's ID#: _____

Insured's Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance:

Dental Coverage? ☐Yes ☐No

Insurance Co. Name: _____

Insurance Co. Address: _____

City: _____ State:_____ Zip:_____

Insurance Co. Phone#: (_____) _____

Group# (Plan, Local or Policy#): _____

Insured's Name: _____Relation: _____

Insured's Birth date: _____/____/____ Insured's ID#: _____

Insured's Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature:_____ Date: ____/____/_____

Medical History

Do you have a personal physician? ☐Yes ☐No

Physician's Name: _____

Phone #: (_____) _____ Date of last visit:_____

Your current physical health is: ☐**Good** ☐**Fair** ☐**Poor**

Are you currently under the care of a physician? ☐Yes ☐No

Please explain:_____

Do you smoke or use tobacco in any other form? ☐Yes ☐No

Have you had any metal rods, pins or implants? ☐Yes ☐No

Are you taking any prescription/over the counter drugs? ☐Yes ☐No

Please list each one: _____

Have you ever taken Phen-Fen? (also known as Redux or Pondimin) ☐Yes ☐No

If so, when? _____

Have you taken Fosamax, or other Bisphosphonates? ☐Yes ☐No

For Women: Are you using a prescribed method of birth control? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No Week #: _____

Are you nursing? ☐Yes ☐No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Herpes/ Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol/ Drug Abuse	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones / Joints/ Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer / Chemo Therapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pace Maker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease / Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack / Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please List any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin
Y	N	Penicillin	Y	N	Codeine
Y	N	Jewelry	Y	N	Any Metals
Y	N	Dental Anesthetics	Y	N	Latex
Y	N	Tetracycline	Y	N	Other_____

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐Yes ☐No

Do you require antibiotics before dental treatment? ☐ Yes ☐No

Your current dental health is: ☐**Good** ☐**Fair** ☐**Poor**

Have you ever had a serious/ difficult problem associated with any previous dental work? ☐Yes ☐No

Do you floss daily? ☐Yes ☐No Brush Daily? ☐Yes ☐No

Type of bristles on your toothbrush: ☐Hard ☐Med ☐Soft

Have you ever had gum treatment? ☐Yes ☐No

Do your gums ever bleed? ☐Yes ☐No

Have you ever had periodontal disease? ☐Yes ☐No

Do you snore? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐Yes ☐No

Are your teeth sensitive to heat, cold, or anything else?_____

Do you clench or grind your teeth? ☐Yes ☐No

Do your teeth feel loose? ☐Yes ☐No

Would you like whiter teeth? ☐Yes ☐No

Are you happy with the way your smile looks? ☐**Yes** ☐**No**

If not, what would you like to change? _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature:_____Date:_____

Office Use Only

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

_____

_____

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control OSHA, the CDC and the ADA.

Medical History Update

Has there been any change in your health status since your last visit? ☐Yes ☐No Patient Signature:_____Date:_____

If yes, please explain:_____ Dentist Signature:_____Date:_____

Has there been any change in your health since your last visit? ☐Yes ☐No Patient Signature:_____Date:_____

If yes, please explain: _____ Dentist Signature:_____Date:_____