

# Welcome to Beavers & Broomfield Family Dentistry!

## PATIENT REGISTRATION

Full Name: \_\_\_\_\_

I prefer to be called: \_\_\_\_\_

Male       Female

Single       Married

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Home phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Email address: \_\_\_\_\_

Emergency Contact:

Full Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

Who may we thank for referring you?

\_\_\_\_\_

Parent/guardian's name(s)

\_\_\_\_\_

Other Household Members (Spouse, children, siblings)

\_\_\_\_\_

\_\_\_\_\_

## FINANCIAL INFORMATION

Guarantor (Person Responsible for this account)

Full Name: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Billing/Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Method of Payment

Cash/Check       Debit/Credit Card       Care Credit

Insurance (less co-payment/deductible)

ArKids #: \_\_\_\_\_

## Dental Insurance Information

Insured/Subscriber Name: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Employer / Company Name

\_\_\_\_\_

Group# &/or Policy #: \_\_\_\_\_

Individual       Family

Secondary Dental Insurance

Insured/Subscriber Name: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Employer / Company Name \_\_\_\_\_

Group# &/or Policy #: \_\_\_\_\_

Individual       Family

Please provide us with your dental insurance card

## FINANCIAL POLICY

### Please Read & Sign Below

I understand that *payment is due @ time of service*. I understand that if Insurance Benefits are filed, I am responsible for deductibles & co-payments. I am aware that *Insurance Estimates are provided as a courtesy and in the event my insurance carrier pays less than estimated, I am fully responsible for the balance*. I request that my insurance company (if applicable) pay directly to the dentist's office. I agree to notify the office of any changes or updates in my personal, financial and/or insurance information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

OVER →

## PATIENT'S MEDICAL HISTORY

Physician Name: \_\_\_\_\_

Physician phone#: \_\_\_\_\_

Current Health Status is:

Excellent  Good  Fair  Poor

Are you taking any medications?  Yes  No

Names/Dosage: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you taking blood thinners?  Yes  No

Do you have a condition that requires you to take antibiotics before receiving dental treatment?

Yes  No

ALLERGIES (check those that apply)

Allergic to Penicillin  Allergic to Latex

Allergic to Aspirin  Allergic to Sulfa Drugs

Allergic to Codeine  Allergic to Erythromycin

Allergic to Keflex  None

Other \_\_\_\_\_

CURRENT OF PREVIOUS CONDITIONS (circle those that apply)

Abnormal Bleeding

Anxiety Attacks

Artificial Bones/Joints

Artificial Heart Valves

Asthma

Autism

Cancer

Congenital Heart Defect

Diabetes

Drug Abuse

Emphysema

Glaucoma

Handicap or disability

OTHER (list any medical conditions you now have or have had in the past): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NONE check here

WOMEN:

Are you taking birth control?  Yes  No

Are you pregnant?  Yes  No

Could you be pregnant?  Yes  No

Are you nursing?  Yes  No

## PATIENT'S DENTAL HISTORY

Previous Dentist: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

What's your reason for today's office visit?

Check-up/cleaning  Tooth-pain  Other

Describe: \_\_\_\_\_

PLEASE CHOOSE APPROPRIATE ANSWER

Have you had dental X-rays in past year?  Yes  No

Do you brush daily?  Yes  No

Do you floss daily?  Yes  No

Do you have an electric toothbrush?  Yes  No

Are you nervous about receiving dental treatment?

Yes  No

Are your teeth sensitive to hot, cold, pressure or sweets?

Yes  No \_\_\_\_\_

Been treated for, or told you have, gum disease?

Yes  No Year: \_\_\_\_\_

Been treated with orthodontic therapy?

Yes  No Year: \_\_\_\_\_

Had oral surgery?

Yes  No Year: \_\_\_\_\_

Bleeding gums?

Yes  No

Clenching/Grinding of teeth?

Yes  No

Do you have a history of TMJ (jaw disorder)?

Yes  No

Are you happy with the way your smile looks?

Yes  No

Would you like whiter teeth?  Yes  No

## AUTHORIZATION & RELEASE

### Please Read & Sign Below

I certify that the information I have provided on this form is complete and accurate. I understand it is my responsibility to notify this office of any changes or updates in medical status. I authorize the dentist to release any information, including diagnosis, treatment plans/records and x-rays to third party payors and/or health practitioners. In consideration of treatment and services rendered to me or my dependants by this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its Financial Policy.

Signature \_\_\_\_\_

Date \_\_\_\_\_