Welcome to Beavers & Broomfield Family Dentistry!

PATIENT REGISTRATION

Full Name:_____
I prefer to be called: _____

Circle: Male Female Single Married

SSN: _____ Date of Birth: _____
Home Address: _____
City:_____State_____ZIP_____
Home phone: _____
Cell phone: _____
Work phone: _____
E-mail address: _____
Employer: _____
Occupation: _____
Emergency Contact
Full name: _____
Phone Number: _____
Relationship:_____

Who may we thank for referring you?
_____

Parent/guardian's name(s), if patient is a minor:
_____

FINANCIAL INFORMATION

GUARANTOR (person responsible for this account,
if different than the Patient &/or patient is a minor)

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)

Dental Insurance Information, if applicable:
(please present you dental insurance card)

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 Information, if applicable:

Insured/Subscriber Name: _____
SSN: _____Date of Birth: _____
Relationship to Patient:_____
Insurance Company: _____
Insurance Co. phone #: _____
Employer/Company Name
_____
Group # &/or Policy #:
_____

Individual ◯ Family ◯

FINANCIAL POLICY
Please Read and Sign Below
I understand that *payment is due at time of service*. I understand that if my account becomes delinquent and is sent to collections I will be responsible for a fee up to 30% of the balance. I understand that if Insurance Benefits are filed, I am responsible for deductibles and 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 and phone # (if known):

_____

Please list the Name and Purpose of medication(s) you take:

_____

Are you taking blood thinners? Yes No
Do you have a condition that requires you to take antibiotics before receiving dental treatment? Yes No
Have you ever had a sleep study? Yes No

ALLERGIES (please CIRCLE all that apply)

Penicillin Latex Aspirin

Sulfa Drugs Codeine Erythromycin

Keflex Other:_____

CURRENT OR PREVIOUS CONDITIONS

Abnormal Bleeding	Heart Attack
Anxiety Attacks	Heart Murmur
Artificial Joint	Heart Disease
Artificial Heart Valves	Hemophilia
Asthma	Hepatitis A B or C
Autism	High Blood Pressure
Autoimmune Disorder	HIV/AIDS
If so, specify:_____	Kidney Problems
Cancer	Lupus
Congenital Heart Defect	Osteoporosis
Diabetes Type: I II	Psychiatric Problems
Drug Abuse	Rheumatic Fever
Emphysema	Seizures
Glaucoma	Tuberculosis
Gum Disease	ADHD

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

_____
_____

Women:
Are you taking birth control? Yes No
Are you pregnant? Yes No
Could you be pregnant? Yes No
Are you nursing? Yes No

FAMILY HISTORY

Current or Previous Conditions of Family Members:

Autoimmune Disorder	Gum Disease
Cancer	Heart Disease
Diabetes Type: I II	Stroke

PATIENT'S DENTAL HISTORY

Previous Dentist and date of last visit:

_____

Please CIRCLE appropriate answer:
Have you had dental x-rays in the past year? Yes No
Do you brush daily? Yes No
Are your teeth sensitive to hot, cold, pressure, or sweets? Yes No
Have you been treated for or told you have gum disease? Yes No
Have you had orthodontic therapy? Yes No
Do your gums bleed? Yes No
Do you clench or grind your teeth? Yes No
Do you have a history of TMD (jaw pain)? Yes No
Do you use tobacco products? Yes No
If yes, what type and how frequently?

_____
What's the reason for today's visit? Describe:

_____
_____

HIPPA Health Insurance Portability and Accountability Act
Please Read and Sign Below
Our facility must inform you (our patient) of your rights as well as our (Beaver's and Broomfield's) policies and procedures pertaining to your personal health information. This information is included in the Notice of Privacy Practices accompanying the Patient Registration herein. By signing below, I acknowledge the Notice included and I've read and understand the guidelines within. I am aware that I may request my own copy at any time.

_____
Signature Date

AUTHORIZATION AND RELEASE
Please Read and Sign Below
I certify that the information I have provided on this form is complete and accurate. I understand that 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 thirds party payors and/or health practitioners. In consideration to treatment and services rendered to me or my dependants in this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its Financial Policy.

_____
Signature Date