Welcome to Beavers & Broomfield Family Dentistry!
Patient Registration

Date:___________ Full Name:_________________________________

I prefer to be called:___________________ Pronouns:________________

Circle: MALE FEMALE NON-BINARY MARRIED SINGLE

SSN:_________________ DOB:_______________ Email:___________________________

Home Address: ______________________City:__________________State:____Zip:_______

Primary Phone:_____________________ (HOME MOBILE WORK)

Secondary Phone:____________________ (HOME MOBILE WORK)

Employer:__________________________ Occupation:________________________

Emergency Contact: _____________________ Relationship:__________ Phone:____________

Who may we thank for referring you?____

Parent/Guardian Name(s) if patient is a minor:_______________________________________

Do you feel comfortable filling out medical forms without help? ALWAYS SOMETIMES NEVER

FINANCIAL INFORMATION

GUARANTOR (person responsible for this account, if different from Patient and/or Patient is a minor)

Full Name:________________ SSN:__________ DOB:___________ Relationship to patient: ___________

Billing/Mailing address:____

Method of Payment: CASH CHECK DEBIT/CREDIT CARD CARE CREDIT INSURANCE*

*less co-pay/deductible

Dental Insurance Information (if applicable)

Insured/Subscriber:________________ SSN:_________ DOB:________ Relationship to patient: ________

Insurance Company:________________ Insurance Co. Phone:_______________ Employer:_____________

Group and/or Policy #:____________________ INDIVIDUAL FAMILY

Secondary Insurance Information (if applicable)

Insured/Subscriber:________________ SSN:_________ DOB:________ Relationship to patient: ________

Insurance Company:________________ Insurance Co. Phone:_______________ Employer:_____________

Group and/or Policy #:____________________ INDIVIDUAL FAMILY

Financial Policy: Please read and sign below.

I understand that **payment is due at the time of service**. I understand that if Insurance benefits are filed, I am responsible for deductibles and copayments. 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:____________________

Patient Medical and Dental History

Physician Name and Phone:____

Please list the Name and Purpose of any medications you take:___________________________

____

Are you taking blood thinners? YES NO

Any conditions that require you to take antibiotics before receiving dental treatment? YES NO

Allergies (please circle all that apply): PENICILLIN LATEX ASPIRIN SULFA DRUGS CODEINE ERYTHROMYCIN KEFLEX OTHER:____________________

Do you use Tobacco Products? NO PREVIOUSLY YES Frequency:__________________

Are you or could you be pregnant?________ Nursing?_______ Taking birth control?________

Current or Previous Conditions:

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

Family History: Current or Previous Conditions:

- Autoimmune Disorder
- Gum Disease

Diabetes—Type I II
Heart Disease

Cancer
Stroke

Please elaborate on any of the above marked conditions: ___________________________________

____

Previous Dentist and date of last visit:____

-Have you had dental x-rays in the past year? YES NO -Do you have a history of jaw pain? YES NO

-Have you had orthodontic therapy? YES NO -Do you clench or grind your teeth? YES NO

-Are your teeth sensitive to hot, cold, pressure, or sweets? YES NO -Do your gums bleed? YES NO

-Do you brush daily? YES NO -What is the reason for today's visit?________________________________

I have read and understand/agree to the Health Insurance Portability and Accountability Act (HIPPA), Authorization and Release, and Cancellation Policy provided by Beavers & Broomfield Family Dentistry.

Signature:__________________________________ Date:___________________________