BEACH ENDODONTICS

PLEASE PRINT
PATIENT'S NAME (Dr. / Mr. / Mrs. / Ms.) ____
HOME ADDRESS (NO P.O. BOX #'S)
____ CITY/STATE/ZIP ____________________________

HOME PHONE ________________ CELL PHONE ________________ WORK PHONE ________________

E-MAIL ADDRESS ______________________________ BEST NUMBER TO CONTACT YOU ____________
SOCIAL SECURITY NUMBER ________________________ DATE OF BIRTH ____________________

EMPLOYER ____

WORK ADDRESS ____________________________________ CITY/STATE/ZIP ______________________

SPOUSE/ RESPONSIBLE PARTY (IF PATIENT IS A MINOR, LIST GUARDIAN) ___________________________

HOME ADDRESS (NO P.O. BOX #'S)
____ CITY/STATE/ZIP ______________________

HOME PHONE ______________ CELL PHONE ________________ WORK PHONE ____________________
SOCIAL SECURITY NUMBER ____________________________ DATE OF BIRTH ______________________

EMPLOYER ____

WORK ADDRESS ___________________________________ CITY/STATE/ZIP ______________________

NEAREST RELATIVE NOT LIVING WITH YOU ____
HOME ADDRESS (NO P.O. BOX #'S)
_____________________________________ CITY/STATE/ZIP _______________________________
HOME PHONE ________________ CELL PHONE ________________ WORK PHONE ________________

NAME OF YOUR DENTIST ______________________________

NAME OF YOUR PHYSICIAN ______________________________

PREFERRED PHARMACY NAME AND PHONE NUMBER ______________________________

WHOM ARE WE TO THANK FOR RECOMMENDING YOU TO OUR OFFICE?
____

DO YOU HAVE ***DENTAL*** INSURANCE? **YES/NO** IS THIS INSURANCE THROUGH YOUR EMPLOYER? **YES/NO**
NAME OF ***PRIMARY DENTAL*** INSURANCE? ________________________
NAME OF ***PRIMARY*** INSURED HOLDER ____________________________
RELATIONSHIP TO INSURED HOLDER _________________________ INSURANCE # ___________________

DO YOU HAVE A SECONDARY ***DENTAL*** INSURANCE? **YES/NO** IS THIS INS.THROUGH AN EMPLOYER? **YES/NO**
NAME OF ***SECONDARY Dental*** Ins. INSURANCE ____________________
NAME OF ***SECONDARY*** HOLDER _______________________________
RELATIONSHIP TO INSURED HOLDER _______________________ INSURANCE # ______________________

THE ABOVE INFORMATION, TO THE BEST OF MY KNOWLEDGE, IS CURRENT AND CORRECT.

PATIENT OR RESPONSIBLE PARTY SIGNATURE ____________________________________ /DATE __________

Health History

PLEASE CIRCLE **"YES"** OR **"NO"** TO **EACH** QUESTION:

1. HAVE YOU BEEN A PATIENT IN THE HOSPITAL IN THE LAST 2 YEARS? YES NO
   IF YES, WHY?

2. HAVE YOU BEEN UNDER A DOCTOR'S CARE DURING THE LAST 2 YEARS? YES NO
   IF YES, WHY?

3. PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING ANY DRUGS YOUR DENTIST HAS PRESCRIBED FOR YOUR CURRENT PROBLEM: **PLEASE NAME**.

4. DO YOU REQUIRE PREMEDICATION PRIOR TO DENTAL PROCEDURES? YES NO
   IF YES, WHY?

5. ARE YOU ALLERGIC TO PENICILLIN, CODEINE, LATEX OR ANY OTHER MEDICATIONS? YES NO
   IF YES, WHAT?

6. HAVE YOU EVER HAD ANY EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT? YES NO
   IF YES, WHEN?

7. HAVE YOU HAD ANY OTHER SERIOUS ILLNESSES? YES NO
   IF YES, WHAT?

8. HAVE YOU EVER TAKEN BISPHOSPHONATE MEDICATION? (EX. FOSAMAX, BONIVA, RECLAST, ZOMETA, ACTONEL) YES NO

. WOMEN: ARE YOU PREGNANT OR NURSING? YES NO

CHECK ANY OF THE FOLLOWING WHICH YOU MAY HAVE HAD:

_____HEART TROUBLE	_____JAUNDICE	_____ARTHRITIS	_____ASTHMA
_____CONGENITAL HEART LESIONS	_____EPILEPSY	_____HEART MURMUR	_____DIABETES
_____RHEUMATIC FEVER	_____HIV ANTIBODY	_____COUGH	_____HEPATITIS
_____HIGH BLOOD PRESSURE	_____TUBERCULOSIS	_____SINUS TROUBLE	_____ANEMIA
_____PSYCHIATRIC	_____STROKE	_____ULCER	_____COLITIS

THE ABOVE INFORMATION, TO THE BEST OF MY KNOWLEDGE, IS CURRENT AND CORRECT.

PATIENT OR RESPONSIBLE PARTY SIGNATURE____/DATE____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

______________________________ ____________________

Signature **Date**

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because ____.

Persons to Whom Information May Be Disclosed:

NAME, RELATIONSHIP, PHONE NUMBER:

________________________ ________________ **(___)_____-__________ Financial/ Health/ Both**

________________________ ________________ **(___)_____-__________ Financial/ Health/ Both**

This authorization will remain in effect until revoked by the patient.

____ Date ____________________

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation i.e. power of attorney forms)