

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?
<u>IF YES, WHY?</u> | YES | NO |
| 2. | HAVE YOU BEEN UNDER A DOCTOR'S CARE DURING THE LAST 2 YEARS?
<u>IF YES, WHY?</u> | YES | NO |
| 3. | PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING ANY DRUGS YOUR DENTIST HAS PRESCRIBED FOR YOUR CURRENT PROBLEM: <u>PLEASE NAME.</u> | YES | NO |
| 4. | DO YOU REQUIRE PREMEDICATION PRIOR TO DENTAL PROCEDURES?
<u>IF YES, WHY?</u> | YES | NO |
| 5. | ARE YOU ALLERGIC TO PENICILLIN, CODEINE, LATEX OR ANY OTHER MEDICATIONS?
<u>IF YES, WHAT?</u> | YES | NO |
| 6. | HAVE YOU EVER HAD ANY EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT?
<u>IF YES, WHEN?</u> | YES | NO |
| 7. | HAVE YOU HAD ANY OTHER SERIOUS ILLNESSES?
<u>IF YES, WHAT?</u> | YES | NO |
| 8. | HAVE YOU EVER TAKEN BISPHTHONATE 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:

- | | | | |
|---|---------------------------------------|--|------------------------------------|
| <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> JAUNDICE | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> CONGENITAL HEART LESIONS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> HIV ANTIBODY | <input type="checkbox"/> COUGH | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> SINUS TROUBLE | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> PSYCHIATRIC | <input type="checkbox"/> STROKE | <input type="checkbox"/> ULCER | <input type="checkbox"/> 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

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.

Signature of Patient or Personal Representative Date _____

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