

PATIENT INFORMATION

Today's Date _____

Name _____ Sex M / F Birthdate _____ SSN _____
Address _____ City _____ State / Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-Mail _____

Marital Status: Single Married Divorced Widowed Separated

Spouse or Parent Name _____ Birthdate _____ SSN _____
In case of emergency, who should be notified? _____ Phone _____
Whom may we thank for referring you? _____

Employment Information

Patient employed by _____ Phone _____
Spouse or Parent employed by _____ Phone _____

Student Information School Name _____ Full or Part Time _____

Insurance Information

Primary Insurance

Name of Insured _____ Relationship to patient _____
Birthdate _____ SSN _____ Ins. ID # _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Group # _____ Ins. Phone # _____
Ins. Co. Address _____ City _____ State / Zip _____

Secondary Insurance

Name of Insured _____ Relationship to patient _____
Birthdate _____ SSN _____ Ins. ID # _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Group # _____ Ins. Phone # _____
Ins. Co. Address _____ City _____ State / Zip _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize Dr. Robert Beebe, Jr. and/or Dr. Sharon L. Clark to release any information, including the diagnosis and the records of any treatment or examination rendered to me, or my dependent(s), during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay all insurance benefits directly to the dentist or dental group otherwise payable to me. I understand that my dental benefit plan may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent(s). I understand that the parent who brings the child in for treatment is financially responsible.

Signature of Patient, Parent or Guardian

Date

PATIENT MEDICAL HISTORY

Physician: _____ Office Phone: _____ Date of Last Exam: _____

1. Are you under medical treatment now? Yes No

2. Have you ever been hospitalized for any surgical operations or serious illness?..... Yes No

3. Are you taking any medication(s), non-prescription medicine?..... Yes No
 If yes, what medication(s) are you taking?

4. Do you use tobacco?..... Yes No Do you use alcohol?..... Yes No

5. Do you use other drugs? Yes No

6. Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocaine)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Aspirin.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Penicillin or Other Antibiotics	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Any Metals (e.g. Nickel, Mercury, etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sulfa Drugs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Latex Rubber.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Barbiturates.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sedatives	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____		
Iodine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____		

7. Date of Last Dental Visit _____
 Date of Last Cleaning _____
 Dentist's Name _____ Telephone Number _____
 Last Date if known:
 Bitewing X-rays _____
 Full Mouth X-rays _____
 Panorex X-rays _____

8. **Women Only:**

a) Are you pregnant or think you may be pregnant? Yes No

b) Are you nursing? Yes No

c) Are you taking birth control pills? (Antibiotics may affect birth control pills)..... Yes No

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Trouble/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Mitro Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement			Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Updated Signature _____ Date _____
 Updated Signature _____ Date _____
 Updated Signature _____ Date _____
 Updated Signature _____ Date _____