More Smiles of Beverly

Welcomes you

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information

Patient Number________________

Name________________ Date________________

SS#/SSN________________ Birthdate ________________ Home Phone ________________

Address ________________ City ________________ State/Prov. ______ Zip/P.C. ______

Email________________ Cell Phone________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College ________________ City ________________ State/Prov. ______ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer ________________ Work Phone ________________

Business Address ________________ City ________________ State/Prov. ______ Zip/P.C. ______

Spouse or Parent/Guardian's Name ________________ Employer ________________ Work Phone ________________

Whom May We Thank for Referring You? ________________

Person to Contact in Case of Emergency ________________ Phone________________

Responsible Party (For Parent/Guardian)

Name of Person Responsible for this Account ________________ Relationship to Patient ________________

Address ________________ Home Phone ________________

Email ________________ Cell Phone ________________

Driver's License # ________________ Birthdate ________________ Financial Institution ________________

Employer ________________ Work Phone ________________ SS#/SIN ________________

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of insured ________________ Relationship to Patient ________________

Birthdate ________________ SS#/SIN ________________ Date Employed ________________

Name of Employer ________________ Union or Local # ________________ Work Phone ________________

Employer Address ________________ City ________________ State/Prov. ______ Zip/P.C. ______

Insurance Company ________________ Group # ________________ Policy/ID# ________________

Ins. Co. Address ________________ City ________________ State/Prov. ______ Zip/P.C. ______

How Much is Your Deductible? ________________ How Much Have You Used? ________________ Max. Annual Benefit ________________

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following on page 2

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Name of Insured ______________________ Relationship to Patient ____________

Birthdate ____________ SS#/SIN ____________ Date Employed ____________

Name of Employer ____________ Union or Local # ______ Work Phone ____________

Employer Address ____________ City ____________ State/Prov. ______ Zip/P.C. ______

Insurance Company ____________ Group # ____________ Policy/ID# ____________

Ins. Co. Address ____________ City ____________ State/Prov. ______ Zip/P.C. ______

How Much is Your Deductible? ________ How Much Have You Used? ______ Max. Annual Benefit ________

Patient Medical History

Physician ______________________ Office Phone ____________ Date of Last Exam ____________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any Cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco/vape?	☐	☐
8. Do you use controlled substances?	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other______________	☐	☐
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsion	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement/Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Issues	☐	☐
Aids or HIV Infection	☐	☐	Thyroid Problem	☐	☐	Stomach Trouble/Ulcers	☐	☐
Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐	Other__________	☐	☐

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Patient Dental History

Name of Previous Dentist and Location ______________________________ Date of Last Exam ____________________

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐	7. Do you bite your lips or cheeks frequently?	☐	☐
2. Do you have any sores or lumps in or near your mouth?	☐	☐	8. Have you ever had any difficult extractions In the past?	☐	☐
3. Have you had any head, neck or jaw injuries?	☐	☐	9. Have you ever had any prolonged bleeding following extractions?	☐	☐
4. Have you ever experienced any of the following Problems in your jaw?			10. Have you had any orthodontic treatment?	☐	☐
			11. Do you wear dentures or partials?	☐	☐
Clicking	☐	☐	if yes, date of placement ____________________		
Pain (joint, ear, side of face)	☐	☐	12. Have you ever received oral hygiene instructions		
Difficulty in opening or closing	☐	☐	regarding the care of your teeth and gums?	☐	☐
Difficulty in chewing	☐	☐	13. Do you like your smile?	☐	☐
5. Do you have frequent headaches?	☐	☐	14. Do you experience dry mouth?	☐	☐
6. Do you clench or grind your teeth?	☐	☐	15. Have you had known exposure to COVID-19? ________________		

WAS YOUR LAST CLEANING WITHIN THE LAST 3 YEARS?______ WHEN WAS YOUR LAST CLEANING? ______________________________

HAVE YOU EVER HAD A DEEP CLEANING? ________ HAVE YOU HAD RECENT MAINTENANCE? ___________________________

ARE YOU UNDER 30 YEARS OF AGE? ____________ DATE OF MAINTENANCE ____________________________________

I HAVE BEEN TOLD I HAVE SOME BONE LOSS IN THE PAST AND BELIEVE I AM PREVENTING FURTHER LOSS BY MY CURRENT HYGIENE PRACTICES? ____
EXPLAIN______________________
(NO TO 2 OR MORE ABOVE MAY INDICATE THE NEED FOR A DEEP CLEANING)

HAVE YOU TRAVELED OUTSIDE OF THE U.S.A? _____________ IF SO, WHAT COUNTRY? ______________________

ARE YOU IN PAIN? _______ HOW LONG HAVE YOU BEEN IN PAIN? _______

ARE YOUR TEETH SENSITIVE TO HOT/COLD FOODS OR LIQUIDS? ______________________ IS THE TOOTH CHIPPED OR CRACKED? ________

DOES THE PAIN KEEP YOU UP AT NIGHT? _____ IS PAIN DULL, SHARP OR THROBBING? _______ DOES PAIN LINGER? ________

WOULD YOU LIKE TO SAVE THE TOOTH IF POSSIBLE ______
(YES TO 5 OR MORE CONSIDER ROOT CANAL OR EXTRACTION)

IF YOU LOSE A FRONT TOOTH WOULD YOU LIKE A TEMPORARY REPLACEMENT? _________ HOW MANY MISSING TEETH DO YOU HAVE? _____

PLEASE INDICATE EXTRACTION DATES __________ HAVE THEY BEEN REPLACED? _______
WHY NOT? (If answered no on previous question) _____________________________

WOULD YOU LIKE MISSING TEETH REPLACED? __________ WOULD YOU PREFER A MOVABLE OR PERMANENT REPLACEMENT? YES OR NO

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 understand that providing incorrect Information can be dangerous to my health. I authorize the dentist and his/her associates to release and/or obtain any information Including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist group insurance benefits otherwise payable to me. I understand that my dental insurance carrier 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 dependents and authorize a credit check for the purpose of obtaining financing for my portion of the treatment planned. This may include an application to our financial partners such as; Care Credit, Wells Fargo, Lending Club, Alphaeon, and One Main, among others.

X______________________________________
Signature of patient (or parent/guardian if minor)

Doctor's Comments ____

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Signature ____ Date ______________________