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 (Confidential)

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

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

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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?	☐	☐
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 regarding the care of your teeth and gums?	☐	☐
Difficulty in opening or closing	☐	☐			
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?	☐	☐			

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.

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

Doctor's Comments ____
____
____
Signature ____ Date ____________________