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
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Do you have any sores or lumps in or near your mouth?	☐	☐
3. Have you had any head, neck or jaw injuries?	☐	☐
4. Have you ever experienced any of the following		
Problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
5. Do you have frequent headaches?	☐	☐
6. Do you clench or grind your teeth?	☐	☐
7. Do you bite your lips or cheeks frequently?	☐	☐
8. Have you ever had any difficult extractions In the past?	☐	☐
9. Have you ever had any prolonged bleeding following extractions?	☐	☐
10. Have you had any orthodontic treatment?	☐	☐
11. Do you wear dentures or partials?	☐	☐
if yes, date of placement _____		
12. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
13. Do you like your smile?	☐	☐
14. Do you experience dry mouth?	☐	☐

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)

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? YES OR NO 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) Date