

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

Name _____

SS#/SSN _____ Birthdate _____

Address _____ City _____

Email _____

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 _____

Address _____

Email _____

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 _____

Birthdate _____ SS#/SIN _____

Name of Employer _____ Union or Local # _____

Employer Address _____ City _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____

How Much is Your Deductible? _____ How Much Have You Used? _____

Patient

Number _____

Date _____

Home Phone _____

State/Prov. _____ Zip/P.C. _____

Cell Phone _____

Relationship
to Patient _____

Home Phone _____

Cell Phone _____

Relationship
to Patient _____

Date Employed _____

Work Phone _____

State/Prov. _____ Zip/P.C. _____

Policy/ID# _____

State/Prov. _____ Zip/P.C. _____

Max. Annual Benefit _____

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

Continued...

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		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	10. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following?		
If yes, please explain _____			Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
			Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
			Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel or any Cancer medications containing bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use tobacco/vape?	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
			12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have, or have you had any of the following?			Women Only:		
	Yes	No	Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsion	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Aids or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement/Implant	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
			Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
			Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
			Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
			Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
			Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
			Respiratory Issues	<input type="checkbox"/>	<input type="checkbox"/>
			Stomach Trouble/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Continued...

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing? Yes No
2. Do you have any sores or lumps in or near your mouth? Yes No
3. Have you had any head, neck or jaw injuries? Yes No
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? Yes No
6. Do you clench or grind your teeth? Yes No
7. Do you bite your lips or cheeks frequently? Yes No
8. Have you ever had any difficult extractions In the past? Yes No
9. Have you ever had any prolonged bleeding following extractions? Yes No
10. Have you had any orthodontic treatment? Yes No
11. Do you wear dentures or partials? Yes No if yes, date of placement _____
12. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No
13. Do you like your smile? Yes No
14. Do you experience dry mouth? Yes No
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)

Office use only:
Processor's signature: _____
Date: _____