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_____ Birth-date _____ 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)

Relationship to Patient _____

Name of Person Responsible for this Account _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birth-date _____ 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 ☐ Cashier's Check Credit Card: ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

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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?	☐	☐
7.1. If so, are you open to looking into options to quit?	☐	☐
7.2 When? (List Date)_____		
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_____	☐	☐

Continue on next page…

Continued…

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			10. Have you had any orthodontic treatment?	☐	☐
Problems in your jaw?			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 payers 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; Wells Fargo, Lending Club, Alphaeon, Lendingpoint, PatientFi, Momnt, Wisetack, CareNowPayLater, and among others.

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

Office use only:
Processor's signature: _____

Date: _____