Patient Information

Patient Name:_____ Preferred Name:_____ Date of Birth:_____
Address:_____ City/Zip_____
Home #:_____ Cell:_____ Work:_____
Patient SS#:_____ Occupation:_____
E-Mail Address:_____
How would you like to be contacted? E-Mail Cell Phone Mail Home Phone All the above

Dental Insurance Information

Name of Subscriber:_____ Date of Birth:_____
Address if Different:_____ City:_____ Zip:_____
Phone #:_____ Cell:_____ Work:_____
SS#:_____ Contract/ID #:_____Relationship to patient:_____
Employer:_____ Name of Insurance Company:_____

Secondary Dental Coverage Please Continue

Name of person with insurance:_____ Date of Birth:_____
SS#:_____ Contract/ID#:_____ Relationship to patient:_____
Employer:_____ Name of Insurance Company:_____

Assignment and Release

I, the undersigned, certify that I, or my dependant have insurance with the company(s) listed above. I authorize and request that my insurance company to pay directly to Dr. Beckwell. I understand that I am financially responsible for all charges, whether or not paid by the insurance. I hereby authorize Dr. Beckwell to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance claims.

_____ _____ _____
Signature of Responsible Party Relationship to patient Date

In Case of Emergency Please Contact (Someone not living with you)

Name:_____ Relationship to Patient:_____
Home #:_____ Cell:_____ Work:_____

How did you hear about our office? (Please circle all that apply)

Yellow Pages	Radio	Insurance	Sign/Front Window
St.Therese Bulletin	St. Isidore Bulletin	St. John Vinny Bulletin	Newsletter
Friend/Family (Name):_____		Returning Patient	Website

Consent for Treatment

As a condition of your treatment by this office, financial arrangements must be made in advance. Payment is due when treatment is completed.
All emergency dental treatment, or any dental treatment performed without previous financial arrangements, must be paid in full at the time treatment is completed.
Patient's who carry dental insurance understand that estimates are not a guarantee of payment from the insurance company. Patient also understands that they are responsible for any balance not paid by the insurance company.
Patient is aware that our office requires a 48 hours notice to cancel appointment. Failure to do so could result in a charge of no less than $50.00.
Finance charge of 1.5% (18% annually) on the unpaid balance will be charge on all accounts 60 days or more unless written financial arrangements are satisfied.
I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating healthcare provider.
I give permission to Dr. Beckwell and his clinical team to make any necessary diagnostic photos or study models to enable complete diagnosis and treatment.
I additionally authorize the release of medical information to the insurance company for legal documentation.

I have read, agree to and understand statements listed above.

_____ _____
Signature of Patient (Parent or Guardian if patient is a minor) Date

Health History

Have you had a serious illness, surgery or been hospitalized in the past 5 years? If so, what was the reason:_____

_____

Date of last medical exam:_____ Are you under the care of a physician now?_____ Reason:_____

_____

What Prescription Medications do you take? **(Include Birth Control as antibiotics interfere.)**_____

_____

_____

Please list your **Allergies** to Medication, Foods or Metals:_____

_____

Have you had to take an antibiotic before having dental treatment done in the past? If yes, what?_____

Do you currently or have you ever had any of the following: (Please mark yes or no)

	Yes	No		Yes	No		Yes	No		Yes	No
Rheumatic Fever	___	___	Are you pregnant?	___	___	Allergic Codeine	___	___	Mitral-Valve Prolapse	___	___
Rheumatic Heart Disease	___	___	Liver Disease	___	___	Radiation for tumor	___	___	Allergic to Aspirin	___	___
Stroke	___	___	Hepatitis	___	___	Diabetes	___	___	Allergic to Latex	___	___
Heart Disease	___	___	Kidney Disease	___	___	Pacemaker	___	___	Allergic to Anesthetic	___	___
Heart Attack	___	___	Arthritis	___	___	Artificial Joints	___	___	Artificial Heart Valve	___	___
High Blood Pressure	___	___	Tuberculosis	___	___	Cancer	___	___	Autoimmune Disorder	___	___
Swollen Ankles	___	___	Lung Ailments	___	___	Heart Murmur	___	___	Allergic to Penicillin	___	___
Chest Pain	___	___	Persistent Cough	___	___	Seizures	___	___	Fainting Spells	___	___
Shortness of breath	___	___	Cough up Blood	___	___	HIV or AIDS	___	___	Low Blood Pressure	___	___
Prolonged Healing	___	___	Hay Fever	___	___	Asthma	___	___	Blood test w/unusual result	___	___
Blood Disorders	___	___	Anemia	___	___	Bruise easily	___	___	Abnormal Bleeding	___	___

Do you have any disease/condition not listed? If so what:_____

Do you get mouth sores, cold sores, canker sores or fever blisters? Yes or No

What concerns do you have regarding dental treatment? (Please circle all that Apply)

Fear of Treatment	Time of Treatment	Financial Concerns
Distance to Office	Embarrassment	Not Understanding Treatment

Do you dislike the color of your teeth?	**Yes**	**No**	**Do you have spaces between your teeth?**	**Yes**	**No**
Do you have chips or uneven edges on your teeth?	**Yes**	**No**	**Do you feel your teeth are too long or too short?**	**Yes**	**No**
Do your gums show too much when you smile?	**Yes**	**No**	**Are your teeth crooked or crowded?**	**Yes**	**No**
Are you self-conscious about your teeth or smile?	**Yes**	**No**	**Would you like to improve your existing smile?**	**Yes**	**No**

Why did you leave your last dentist? _____

Previous Dentist :_____ **Phone #:**_____

I have read and answered the above questions to the best of my knowledge:

_____ _____

Signature of Patient (Parent or Guardian if patient is a minor) Date

UpDate:

Changes:_____ Date:_____ Initals:_____

Changes:_____ Date:_____ Initals:_____

Changes:_____ Date:_____ Initals:_____

Changes:_____ Date:_____ Initals:_____