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104 Mesa, Arizona 85205 (480)834-4277

Information for Child

*Required information

*Patient Name: _____ *Date: _____

Last First MI (Legal Name) Preferred

*Gender: Male Female *Social Security #: _____ *Birth Date: _____

*Phone: Home: _____ Cell: _____ Email: _____

*Address: _____

Street Apartment #

City State Zip Code

Whom may we thank for referring you to our practice? _____

Are you a full time student? Yes No If Yes, Name of School: _____

Person(s) Financially Responsible for Account

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

City State Zip Code

Employer Name _____

Employer Address _____

Street City State Zip Code Phone #

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? Yes No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Insurance Company Information

Insurance Plan Name and Address: _____

Secondary
Name of Insured: _____ Self Spouse Other

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Insurance Plan Name and Address: _____

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist. I authorize use of this signature on all insurance submissions. I am aware of the HIPPA policies that are posted in the office. I have been presented with a copy of the office's financial policy and agree to the terms presented to me. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____



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Health Information

Name: _____ Date: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Alcohol Dependency | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Alzheimers/Dementia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Parkinsons Disease | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Headaches | Due date: _____ | OTHER: |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Premedication | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | |
| | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | |

- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- List any medications/Drugs/Pills/Herbs/Vitamins you are taking _____
- List any allergies to medications you have _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____
- Are you currently breastfeeding your child Yes No
- Tobacco use Cigarettes/Cigars Chewing Tobacco How often? _____

Dental Information

- Date of Last Dental Visit: _____ Reason for this visit: _____
- Are you having any dental concerns at this time? Yes No
- How often do you brush your teeth? _____ Floss? _____
- How would you describe your dental health? Good Fair Poor
- What type of toothbrush are you using? Hard Medium Soft Electric
- Do your gums bleed when you floss? Yes No
- Have you experienced any pain in your jaw or limited mouth opening? Yes No
- Do you clench or grind your teeth? Yes No
- Do you have sensitivity to: Hot/Cold Sweet/Sour Air/Water
- Have you had orthodontic treatment? Yes No
- Have you ever had any periodontal (gum) treatment of any kind? Yes No
- Would like whiter teeth? Yes No
- Please list any other concerns that you may have: _____
- Have you ever had any complications following dental treatment? Yes No
- If yes, please explain: _____

Consent for Services

I have reviewed this questionnaire and answered its questions accurately to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine the appropriate dental treatment. I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist. I authorize use of this signature on all insurance submissions.

I am aware of the HIPPA policies that are posted in the office.

I have been presented with a copy of the office's financial policy and agree to the terms presented to me.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____