BEAVERCREEK
DENTAL

Patient Information

Patient Name: FIRST _____ MI _____ LAST _____

Today's Date: _____ Patient's Birthdate: _____ Sex: **Male or Female**

Address: _____ City: _____

State: _____ Zip: _____ Phone Number: CELL_____ HOME _____

Occupation: _____ Employer/School: _____

How did you hear about our office? Email

Emergency Contact Information

Name: _____ Relationship to Patient: _____

CELL #: _____ HOME #: _____

Dental History

Reason for today's visit _____

Former Dentist _____ Date of last visit _____

What was done at the last visit? _____

Please circle to indicate if you have experienced any of the following:

Bad Breath **Bleeding gums** **Blisters on lips or mouth** **Clicking or popping jaw**

Cigarette, pipe, cigar or marijuana smoking **Dry mouth** **Grinding/clenching**

Tender/swollen gums **Loose teeth** **Broken fillings** **Mouth Breathing** **Brushing pain**

Orthodontic treatment **Periodontal treatment** **Sensitivity to cold** **Sensitivity to hot**

Sensitivity to sweets **Sensitivity when biting** **Lip or cheek biting** **Sleep Apnea**

How often do you floss? _____ How often do you brush? _____

Do you wear any night time appliances? _____

Would you be interested in discussing sedation options for your appointments? **Yes or No**

Medical History

Please check "yes" or "no" to indicate if you have had any of the following:

	Yes	No
Alzheimer's Disease		
AIDS/HIV		
Anemia		
Arthritis/Gout		
Artificial Heart Valve		
Artificial Joints		
Asthma		
Back Problems		
Bleeding Excessively		
Blood Disease		
Cancer		
Chemical Dependency		
Chemotherapy/Radiation		
Circulatory Problems		
Congenital Heart Disorder		
Cortisone Treatments		
Cough- Persistent or Bloody		
Cold Sores		
Diabetes		
Emphysema		
Epilepsy/Seizures		
Fainting/Dizziness		
Frequent Headaches		
Glaucoma		
Heart Murmur		
Heart Surgery		

	Yes	No
Hay Fever		
Heart Disease		
Heart Attack/Failure		
Heart Stents		
Heart Pacemaker		
Hepatitis A, B, C		
Herpes		
High Blood Pressure		
Jaundice		
Kidney Disease/Dialysis		
Liver Disease		
Lung Disease		
Low Blood Pressure		
Mitral Valve Prolapse		
Neurodivergent/Autism		
Osteoporosis		
Parkinsons Disease		
Scarlet Fever		
Sinus Problems		
Sexually Transmitted Disease		
Stroke		
Thyroid Problems		
Tumor on Head or Neck		
Tuberculosis		
Ulcers		

Women: Are you pregnant or currently nursing? **Yes or No**

If you marked yes to any of the above, please explain:

_____

List any medications and the diagnosis:

_____

_____

_____

Preferred pharmacy: _____

Please circle if you have any of the following medication allergies:

Aspirin Barbiturates Codeine Iodine Latex Local Anesthetic Penicillin Sulfa Other _____

Patient signature: _____

Doctor signature: _____

FINANCIAL AGREEMENT

I am responsible for my balances if any of the following occurs:

1. I am not eligible for insurance
2. The treatment goes over my yearly maximum
3. My insurance company denies any treatment
4. I prevent or delay payment by not complying with requests for more information on insurance forms or request for signatures
5. I fail to complete my treatment and it results in non-payment by the insurance company
6. Lab costs are incurred due to missed appointments
7. I received my insurance check and did not send it to the office

Your insurance policy is a contract between you and your insurance company. Based on the information we receive from your insurance, we then provide an **ESTIMATED** portion for the treatment needed. **THIS PAYMENT WILL BE DUE AT THE TIME OF SERVICE OR PRE-COLLECTED**. As a courtesy our office will assist in making collections from the insurance company by filing the necessary forms; however, this does not guarantee payment from them. If there is a balance due after your insurance pays their portion, you will be billed for any amount that is still remaining, as you are responsible for any charges exceeding your plans benefits.

A $50 FEE WILL BE CHARGED FOR LATE NOTICE CANCELLATIONS AND MISSED APPOINTMENTS. WE REQUIRE A 48 HOUR NOTICE FOR ANY APPOINTMENTS THAT NEED TO BE RESCHEDULED OR CHANGED.

By signing below, you are agreeing to our financial agreement and acknowledging you received a copy of our Notice of Privacy Practices

Print Name:

X_____

Sign:

X_____

Date:

X_____