We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you.

Name ____ preferred name __________________
Address ____
Birthdate _________________ SSN ______________________ Gender: {M} {F} Married: {Y} {N}
Cell phone _________________ Home phone ________________ Work phone ______________
Email _________________________________
How did you hear about us? ____________________________________
If it was a friend, please write down their name so we can thank them __________________
Please circle your preferred communication method for the following:
How should we contact you if we have any questions? {text} {email} {phone call}
How should we confirm appointments? {text} {email} {phone call}
How should we remind you of your hygiene appointments? {text} {email} {phone call}

Insurance Policy #1

Your relationship to the subscriber - {self} {spouse} {child}
Subscriber's name ________________________________ Subscriber's ID # ___________________
Insurance company ______________________________ Employer __________________________
Group name ____________________________________ Group # __________________________

{please present insurance card to receptionist}

Insurance Policy #2 {n/a}

Your relationship to the subscriber - {self} {spouse} {child}
Subscriber's name __________________________________ Subscriber's ID # ________________
Insurance company ________________________________ Employer _______________________
Group name ______________________________________ Group # __________________________

Please mark any questions you would answer {YES}

Are you apprehensive about dental care? ___
Have you had a bad dental experience? ___
Do you avoid brushing due to pain? ___
Do you use fluoride toothpaste? ___
Do you have pain while eating/drinking? ___
Do you take medication for jaw pain? ___
Do you have any areas that catch food? ___
Do you floss? How often: ___________
Do you have dry mouth? ___

Are you happy with your smile? ___
Are you interested in whitening? ___
Do you smoke? ___ Chew tobacco? ___
Have you ever had gum grafting? ___
Do you gag easily? ___
Do you clench/grind your teeth? ___
Have you ever had a deep cleaning? ___
When was your last cleaning? ___________
Do you brush your tongue? ___

What are some of your dental goals: ____

Do you have a medical doctor/physician? {yes} {no} Last visit? ______________________

Physician's name ______________________________________

Physician's phone _____________________________________

Your current physical health is: {good} {fair} {poor}

Are you currently undergoing treatment under the care of a physician? {yes} {no}

If yes, please explain: ____

Have you ever had surgery for:

Artificial heart valve? {yes} {no}

Artificial joint replacement? {yes} {no} - if yes, which joint? _________________________

Have you ever take premedication for dental appointments? {yes} {no}

Please list any medications you are taking: ____

____

Any dietary or herbal supplements: ____

Please list any allergies: ____

What's your typical blood pressure? ________________________ typical heart rate? _________

Do you have Diabetes? {yes - *type I* or *type II*} {no} {pre-diabetic}

If female, are you pregnant? {yes} {no} .... Are you nursing? {yes} {no}

Please check all that apply

Heart trouble	{yes}	{no}	Excessive/prolonged bleeding	{yes}	{no}
Heart murmur	{yes}	{no}	Thyroid problem	{yes}	{no}
Heart surgery	{yes}	{no}	Hepatitis: (*type*________)	{yes}	{no}
Heart pacemaker	{yes}	{no}	Jaundice	{yes}	{no}
Rheumatic fever	{yes}	{no}	Cancer (*type* ________________)	{yes}	{no}
Congenital heart defects	{yes}	{no}	Chemo/radiation (*when*__________)	{yes}	{no}
Stroke	{yes}	{no}	Arthritis	{yes}	{no}
Ulcers/GERD	{yes}	{no}	Osteoporosis/treatment w/Bisphosphonates	{yes}	{no}
Kidney trouble/dialysis	{yes}	{no}	HIV positive/AIDS	{yes}	{no}
Tuberculosis/lung disease	{yes}	{no}	Emphysema	{yes}	{no}
Asthma	{yes}	{no}	High blood pressure	{yes}	{no}
Sinus troubles	{yes}	{no}	History of/or current eating disorder	{yes}	{no}
Epilepsy/seizures	{yes}	{no}	STDs (*type*________________)	{yes}	{no}
Fainting spells	{yes}	{no}	Frequent headaches	{yes}	{no}
Anemia	{yes}	{no}	Shingles	{yes}	{no}
Leukemia	{yes}	{no}	Psychiatric problems	{yes}	{no}

➢ I authorize Dr. Carmody to perform diagnostic procedures and treatment as may be necessary for proper dental care.

➢ I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.

➢ The information that I have given today is correct to the best of my knowledge and I understand that this information will be held in the strictest confidence.

➢ It is my responsibility to inform Beardslee Dental of any changes and updates to my medical status moving forward.

Patient signature ____ Date ___________