DATE _____ A B C

CONFIDENTIAL PATIENT INFORMATION

Patient's Name _____ (LAST / FIRST / MIDDLE)

Residence _____ (STREET / CITY, STATE / ZIP)

Birthdate _____ Social Security #_____ Nickname _____

Guardian / Parent Name (If Patient is a Minor) _____

Name and age of other siblings or children _____

School _____ Grade _____

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

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name _____ (LAST / FIRST / MIDDLE) Marital Status _____

Residence _____ (STREET / CITY, STATE / ZIP)

Mailing Address _____ (STREET / CITY, STATE / ZIP)

How long at this address? _____ Own □ Rent □

Previous Address (If less than 3 years) _____ (STREET / CITY, STATE / ZIP)

Home # _____ Cell # _____ Work # _____

Email Address _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ Years Employed _____

Spouse's Name _____ (LAST / FIRST / MIDDLE)

Social Security # _____ Birthdate _____ Relationship to Patient _____

Home # _____ Cell # _____ Work # _____

Employer _____ Occupation _____ Years Employed _____

INSURANCE INFORMATION

Policy Holder's Name _____ (LAST / FIRST / MIDDLE)

Social Security # _____ Policy Holder Birthdate _____

Insurance Company _____ ID / Group # _____

Insurance Phone # and Address _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Address, City and State _____

Contact # _____ Relationship to Patient _____

I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT REPORTS MAY BE OBTAINED. I AUTHORIZE MICHAEL A. BEIM, D.D.S., P.A. TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY. I HEARBY AUTHORIZE MY INSURANCE COMPANY TO SEND PAYMENT DIRECTLY TO MICHAEL A. BEIM, D.D.S., P.A.

SIGNATURE (PARENT'S SIGNATURE IF PATIENT IS A MINOR) _____

MEDICAL AND HEALTH HISTORY INFORMATION

Patient's Dentist ____
Date of last dental visit ____
Do you need a referral to a Dentist? ____
What concerns you most about your teeth? ____
Has an Orthodontist been previously consulted? ____
Are antibiotics needed for a teeth cleaning? ____
Any dental work that needs to be completed prior to beginning treatment? ___________________________
Patient's Physician ______________________________ Date of last Physical Exam ______________
Is the patient under the care of a Physician at this time? Please explain: ___________________________
____
Do you play a musical mouth instrument? ____
Are you aware that some appointments may be during school or work hours? ___________________________
List any medications being taken at this time: ____
List any drug/ miscellaneous allergies: ____
Please explain any medical/ dental problems or surgeries you have had: ___________________________
____
Do you have any disease, medical, or dental condition not listed below that you feel we should be aware of?______________
____

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING MEDICAL / DENTAL PROBLEMS? PLEASE MARK BELOW.

Abnormal Bleeding	Yes	No	Epilepsy / Convulsions / Seizures	Yes	No	Thyroid Problems	Yes	No
Kidney Disease	Yes	No	Bone Disorders	Yes	No	AIDS / HIV Positive	Yes	No
Liver Disease	Yes	No	Cancer or Tumor	Yes	No	Fainting or Dizziness	Yes	No
Heart Problems	Yes	No	Hemophilia / Prolonged Bleeding	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Bruise or Bleed Easily	Yes	No	Hepatitis	Yes	No
Sinus Problems	Yes	No	Tuberculosis / Positive PPD	Yes	No	Sexually Transmitted Disease	Yes	No
Pregnant Now	Yes	No	Asthma or Hay Fever	Yes	No	Arthritis	Yes	No
Heart Murmur / MVP	Yes	No	Alcoholism / Drug Addiction	Yes	No	Cold Sores / Herpes	Yes	No
Latex Allergy	Yes	No	Frequent Colds / Sore Throat	Yes	No	Nervous Disorders	Yes	No
Painful Joints	Yes	No	Anemia	Yes	No	Disabilities	Yes	No
Plastic / Metal Allergy	Yes	No	Ear Infections	Yes	No	Implants	Yes	No
Finger / Thumb Sucking	Yes	No	Mouth Breathing	Yes	No	Tooth / Jaw Trauma	Yes	No
Lip / Tongue Biting	Yes	No	Missing Permanent Teeth	Yes	No	Tongue Thrust	Yes	No
Clenching or Grinding	Yes	No	Tonsils / Adenoid Problems	Yes	No	Speech Problems	Yes	No
Jaw Clicking or Popping	Yes	No	Dental Pain	Yes	No	Cavities Now	Yes	No
Smoke / Chew Tobacco	Yes	No	Headaches	Yes	No	Extra Teeth	Yes	No

I AFFIRM THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE IMMEDIATELY OF ANY CHANGES IN MEDICAL STATUS.

______________________________ ______________________
SIGNATURE OF PATIENT/ PARENT OR GUARDIAN DATE

_ _

OFFICE USE ONLY ***OFFICE USE ONLY*** ***OFFICE USE ONLY***

I VERBALLY REVIEWED THE MEDICAL AND DENTAL INFORMATION ABOVE WITH THE PATIENT/ PARENT OR GUARDIAN NAMED HEREIN.

SIGNED ______________________________ DATE ____________________