BEACH ROAD
DENTISTRY

Patient Information

Patient's Name _____ Preferred Name _____ Sex ____
(First) (Middle) (Last)

Date of Birth _____ Age _____ Patient's Social Security No. _____

Mailing Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Work Phone _____ Cell Phone _____

Marital Status: _____ Are you a student? ☐ Y ☐ N What school do you attend? _____

Employer Name _____ Job Title _____

Emergency contact: _____
(Name) (Phone number) (Relation)

Please indicate your preferred method of contact: _____ E-mail address _____

Would you like to receive text messages to confirm your dental appointments? ☐ Y ☐ N

Would you like to be contacted via email to confirm your dental appointments? ☐ Y ☐ N

How did you hear about Beach Road Dentistry? _____

Dental Insurance Information

Primary Insured's Name _____ Insured's Soc. Sec. No. _____

Insured's DOB _____ Primary Insured's Employer _____

Insurance Co. _____ Insurance Co. Phone No. _____

Insurance Co address _____
(Street) (City) (State) (Zip)

Subscriber No. _____ Group No. _____ Do you have a secondary dental insurance: ☐ Y ☐ N

Responsible Party Information
(Please fill out if someone other than yourself is financially responsible for your account.)

Name _____ Relation to self: _____

DOB _____ Marital Status _____ Social Security No. _____

Address if different from above _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient / Guardian Signature _____ **Date:** _____

PATIENT'S NAME: _____ DOB: _____

MEDICAL HISTORY: *Do you currently have or have you ever had any of the following?*

☐ Y ☐ N Acid Reflux/GERD
☐ Y ☐ N ADD/ADHD
☐ Y ☐ N Allergies/Seasonal Allergies
☐ Y ☐ N Alzheimer
☐ Y ☐ N Anemia
☐ Y ☐ N Anxiety
☐ Y ☐ N Arthritis
☐ Y ☐ N Asthma
☐ Y ☐ N Artificial Joints or joint replacement
☐ Y ☐ N Autism
☐ Y ☐ N Bleeding Disorder
☐ Y ☐ N Blood Pressure
If yes: ☐ High ☐ Low
☐ Y ☐ N Bronchitis
☐ Y ☐ N Cancer: Type _____
☐ Y ☐ N Cerebral Palsy
☐ Y ☐ N Chemotherapy/Radiation
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Convulsion/Epilepsy
☐ Y ☐ N Cholesterol
If yes: ☐ High ☐ Low
☐ Y ☐ N Chrons Disease
☐ Y ☐ N Depression
☐ Y ☐ N Dementia
☐ Y ☐ N Diabetes: Type_____
☐ Y ☐ N Dialysis
☐ Y ☐ N Drug/Alcohol Abuse
☐ Y ☐ N Eating Disorder
☐ Y ☐ N Endometriosis
☐ Y ☐ N Fainting Spells
☐ Y ☐ N Handicap/Disabilities
☐ Y ☐ N Headaches/Migraines
☐ Y ☐ N Hearing Impairment
☐ Y ☐ N Heart Disease
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Heart Surgery
☐ Y ☐ N Hepatitis: Type _____
☐ Y ☐ N HIV/AIDS
☐ Y ☐ N Immune Suppressive Disorder
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Liver Disease
☐ Y ☐ N Lung Problems
☐ Y ☐ N Mental Disorder
☐ Y ☐ N Nervous System Disorder
☐ Y ☐ N Parkinson's disease
☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Seizures
☐ Y ☐ N Smoker/Tobacco Use
☐ Y ☐ N Speech Disorder
☐ Y ☐ N STD/ Venereal Disease
☐ Y ☐ N Stroke
☐ Y ☐ N Thyroid: Type _____
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Tumors/Growths
☐ Y ☐ N ODD (Oppositional Defiant Disorder)
☐ Y ☐ N OCD (Obsessive Compulsive Disorder)
☐ Y ☐ N Osteoporosis

Do you take an antibiotic prior to your dental appointments? ☐ Y ☐ N

WOMEN:
Are you pregnant? ☐ Y ☐ N
Are you nursing? ☐ Y ☐ N

Have you ever taken a bisphosphonate medication by mouth or by IV? (Examples of this type of medication may include but are not limited to: Fosamax, Boniva, Aredia, Zometa, and Actonel) ☐ Y ☐ N Please explain:_____

Have you experienced any other medical conditions not listed above? ☐ Y ☐N Please list: _____

Are you presently under the care of a physician? ☐ Y ☐ N Physicians Name: _____Reason for care _____

Have you ever been hospitalized? ☐ Y ☐ N Please explain: _____

ALLERGIES: Are you allergic to any of the following?

☐ Y ☐ N Amoxicillin
☐ Y ☐ N Aspirin
☐ Y ☐ N Clindamycin
☐ Y ☐ N Codeine
☐ Y ☐ N Dental Anesthetic
☐ Y ☐ N Eggs
☐ Y ☐ N Erythromycin
☐ Y ☐ N Latex
☐ Y ☐ N Penicillin
☐ Y ☐ N Red Dye
☐ Y ☐ N Sulfur
☐ Y ☐ N Tylenol/Acetaminophen

Are you allergic to any other medications or foods that are not listed above? _____

DENTAL HISTORY:

What is the reason for your dental visit today? _____
Have you ever had a problem associated with previous dental work? ☐ Y ☐ N Please explain: _____
Name of your previous dentist: _____ Date of your last dental visit: _____

☐ Y ☐ N Do you brush your teeth daily?
☐ Y ☐ N Do you use dental floss?
☐ Y ☐ N Do you bite your nails?
☐ Y ☐ N Do you grind or clench your teeth?
☐ Y ☐ N Do your gums bleed while brushing or flossing your teeth?
☐ Y ☐ N Do you avoid brushing areas of your mouth due to pain?
☐ Y ☐ N Are you a mouth breather?
☐ Y ☐ N Have you had a facial or jaw injury?

MEDICATIONS: Please list all the medications, vitamins and supplements you are currently taking. If you have a list prepared please give this to the receptionist so it can be scanned into your chart.

Medication and Dose	*How much do you take and when?*	*What do you take it for?*	*Date started*

How would you like your smile to look? _____

If there any information you feel we should know regarding your dental treatment, please let us know. _____

_____

*** By signing below you are agreeing that the information above is accurate and complete to the best of your knowledge and you have provided Beach Road Dentistry with all the information needed to insure you have the most proper and safest care possible.*

Patient Signature: _____ **Date**_____