Beachwood DENTAL

3690 Orange Place Suite 560 • Beachwood, Ohio 44122
p. 216.831.5661 • f. 216.831.5378
www.BeachwoodDental.com

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (_____) _____

Patient Name _____

Street Address _____ City _____ State _____ Zip _____

E-mail _____ Cell Phone (_____) _____

Sex ☐ M ☐ F Age _____ Birth Date _____ ☐ Divorced ☐ Partnered for _____

☐ Married ☐ Separated ☐ Widowed ☐ Single ☐ Minor

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (_____) _____

Spouse/Parent Name _____ Spouse/Parent Birth Date _____

Spouse/Parent Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse/Parent Social Security # _____

Name of Dental Insurance Company _____

Dental Insurance Member ID # _____ Group # _____

Dental Insurance Phone (_____) _____

In case of emergency, who should be notified? _____ Phone (_____) _____

PATIENT REFERRAL

How did you hear about us? ☐ WTAM 1100 Bill WIlls ☐ ESPN ☐ 92.3 The Fan ☐ Kiss 96.5 ☐ Google ☐ Facebook

☐ Other: _____

MEDICAL HISTORY

What is the reason for your visit? _____

Previous Dentist _____ Date of Last Dental Visit _____

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

Physician's Name _____

How often do you brush? _____ Do you use a power brush? ☐ Yes ☐ No

Have you ever been told you have gum disease? ☐ Yes ☐ No

What do you use to clean between your teeth? ☐ Floss ☐ Proxy Brush ☐ Soft Picks ☐ Other: _____

Over

MEDICAL HISTORY CONT'D.

Have you ever had any of the following? (check boxes that apply):

- ☐ Allergies
- ☐ Arthritis
- ☐ Artificial Heart Valves or Joints
- ☐ Abnormal Bleeding
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ HPV
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Anxiety
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Respiratory Disease
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Ulcer

Are there any other medical conditions/concerns we should be aware of? _____

Are you allergic to any medications? (check boxes that apply):

☐ Penicillin ☐ Aspirin ☐ Latex
☐ Codeine ☐ Anesthetics ☐ Other_____

Are you currently taking any medication? ☐ Yes ☐ No If so, what?_____

_____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Do you smoke or use smokeless tobacco? ☐ Yes ☐ No How often?_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

For Women: Are you pregnant? ☐ Yes ☐ No Due date? _____

Are you currently nursing? ☐ Yes ☐ No Are you currently taking Birth Control pills? ☐ Yes ☐ No

DENTAL HISTORY

Do you have any type of dental appliance? ☐ Yes ☐ No

Do you have or have you had any of the following:

- ☐ Bleeding, sore gums
- ☐ Unpleasant taste/bad breath
- ☐ Frequent blisters, lips/mouth
- ☐ Clicking/popping jaw
- ☐ Difficulty opening or closing jaw
- ☐ Missing teeth
- ☐ Loose teeth
- ☐ Sensitive to hot
- ☐ Sensitive to cold
- ☐ Sensitive to sweets
- ☐ Sensitive when chewing
- ☐ Clenching/grinding teeth
- ☐ Sinus trouble
- ☐ Frequent headaches/Migraines
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Dry mouth

Have you ever had difficulty with previous dental treatments? _____

_____

Are you happy with your smile? ☐ Yes ☐ No Would you like to improve the color of your teeth? ☐ Yes ☐ No

Would you like to improve the size/shape of your teeth? ☐ Yes ☐ No

Would you like to improve the alignment of your teeth? ☐ Yes ☐ No

Do you play sports? ☐ Yes ☐ No Have you had excessive bleeding requiring special treatment? ☐ Yes ☐ No

Are you afraid of dental treatment? How fearful on a scale of 1 (least) to 10 (most)? _____

Did you ever have braces, orthodontic treatment or had your bite adjusted? ☐ Yes ☐ No

Is there anything about the appearance of your teeth that you would like to change? _____

_____

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ☐ Yes ☐ No

Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ☐ Yes ☐ No

Do your gums bleed or are they painful when brushing or flossing? ☐ Yes ☐ No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X_____Date_____

Patient or guardian signature

Updates:

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____ 20_____

Print Patient Name _____

Signature _____

Relationship to Patient _____

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ESTABLISHED PATIENT – DENTAL MEDICAL AND HISTORY UPDATE

To ensure the highest quality of healthcare, we ask that you complete this patient update form.

Today's Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____

Reason for today's visit: _____

Contact information

Email address: _____ Phone number: _____

Address: _____

Preferred method of contact: _____

	NO	YES	IF YES, PLEASE EXPLAIN
Any changes in insurance?			
Any change in health since last dental visit?			
Any surgeries or hospitalizations since last dental visit?			
Any change in dental health since last dental visit?			
Any new family history of cancer or other health issues?			
Are you taking any medications or supplements (prescription and/or non-prescription)?			
Are you allergic to any medications, foods, or latex?			

I Certify *that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.*

X_____ X_____

Patient Signature Date

X_____ X_____

Doctor Signature Date