BEISCHEL
FAMILY | DENTAL

7125 E. Lincoln Drive, Suite B-108
Paradise Valley, AZ 85253
480.948.1450

Today's Date: _____

Patient Name: _____
Last First MI

What You Prefer To Be Called: _____ [] M [] F

Birthdate: _____/_____/_____ Age: _____ SS#: _____

Mailing Address: _____

_____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

E-mail Address: _____

Employer: _____

Employer's Address: _____

_____

Occupation: _____

Status: [] Single [] Married [] Divorced [] Separated [] Widowed

Spouse's Name: _____

Do you have children? [] Yes [] No How Many? _____

In Event of an Emergency:

Who should we contact? _____

Relation: _____

Home Phone #: _____

Work or Cell #: _____

M.D. Name: _____

M.D. Phone #: _____

List Medical Specialists you see: _____

_____

_____

Phone #'s: _____

_____

_____

Nearest Friend or Relative not living with you:

Name: _____

Phone #: _____

Person ultimately responsible for account:

Name: _____

Relation: _____

Address: _____

_____

SS #: _____

Driver's License #: _____

State: _____ Expiration: _____

Work Phone #: _____

Payment Method: [] Cash [] Check

_____ ____/____

[] Credit Card – enter card # above (if accepted) CCV _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any and all balances not paid by my insurance company within 45 days.

_____ **Initials**

Primary Dental Insurance (if any)

Co. Name: _____

Address: _____

_____

Phone #: _____ ID #: _____

Insured's Name: _____ Relation: _____

Date of Birth: _____/_____/_____ SS#: _____

Insured's Employer: _____

Secondary Dental Insurance (if any)

Co. Name: _____

Address: _____

_____

Phone #: _____ Group #: _____

Insured's Name: _____ Relation: _____

Date of Birth: _____/_____/_____ SS#: _____

Insured's Employer: _____

OVER

Do you have or have you ever had any of the following diseases, medical conditions or procedures?

Y N **AIDS/ARC Aids Related Complex**
Positive HIV Blood Test
When? _____
Y N **Allergy to Anesthetics**
What? _____
Y N **Allergy to Latex Rubber**
Reaction? _____
Y N **Anemia**
Any Bleeding/Clotting or Other Blood Disorders _____
Y N **Any Allergies (Note Below)**
Y N **Anorexia/Bulimia/Any Eating Disorder**
What? _____
Y N **Arthritis/Rheumatism**
Y N **Asthma**
Y N **Back Problems**
What? _____
Y N **Blood Transfusion**
When? _____
Y N **Cancer/Tumors**
Diagnosed _____
Radiation or Chemotherapy?
When? _____
Y N **Chemical/Alcohol Dependency**
What? _____
Consumed/Week _____
Y N **Circulatory Problems**
Y N **Cosmetic Surgery:** _____
Y N **Wear Contact Lenses**
Y N **Emphysema**
Y N **Depression;** treatment; _____
Y N **Diabetes**
Y N **Difficulty Breathing/Respiratory Problems**
Y N **Epilepsy/Seizures**
Y N **Fainting**
Y N **Frequent Fever**
Y N **Frequent Neck Pain**
Y N **Glaucoma**
Y N **Hay Fever**
Y N **Headaches;** Frequency:_____
Severity: _____
Y N **Hearing Loss/Aids**
Y N **Heart Problems of Any Type**
Y N **Heart Attack/Stroke;** when_____
Y N **Heart Surgery**; when _____
Y N **Heart Murmur;** diagnosed: _____
Y N **Rheumatic Fever, Scarlet Fever or Congenital Heart Defect**
Y N **Angina/Chest Pains**
Y N **Artificial Heart Valve**
Y N **Mitral Valve Prolapse/Floppy Valve**
Y N **Pacemaker;** placed: _____
Y N **High Blood Pressure**
Y N **Low Blood Pressure**
Y N **Hepatitis**
Y N **Hypoglycemia**
Y N **Implants of Any Type**
Artificial Joints/Bones: _____
Y N **Jaw Problems – TMD/TMJ**
Left Right Both (circle one)
Y N **Kidney Disease**
Y N **Liver Disease**
Y N **Nervous Problems**
Y N **Night Sweats**
Y N **Recreational Drug Use;** what: _____
Y N **Shingles**
Y N **Sinus Problems**
Y N **Swollen Lymph Nodes**
Location: _____
Y N **Thyroid Condition**
Y N **Tuberculosis/TB**
Y N **Ulcer/Stomach Problems**
Y N **Unexplained Weight Loss**

Reason for today's visit: [] Exam [] Emergency [] Consultation
Are you in pain? [] Yes [] No How long? _____

Please indicate any of the following problems:
[] Discomfort, Clicking, Popping or Locking Jaw [] Lost/Broken Filling(s) [] Stained Teeth

[] Red, Swollen or Bleeding Gums [] Teeth Grinding/Clenching [] Bad Breath

[] Sensitive Tooth, Teeth, Gums or Jaw [] Ringing in Ears [] Other: _____

[] Blisters/Sores in or Around the Mouth [] Broken/Chipped Teeth _____

[] Food Catching Between Teeth [] Swelling or Sore(s) in Mouth _____

Do you require pre-medication? [] Yes [] No [] Don't Know
Previous Dentist: _____ Phone #: _____
Last Dental Exam: _____ Last Dental X-Rays: _____
How often do you brush? _____ How often do you floss? _____
What type of toothbrush do you use? [] Manual (what kind)_____ [] Electric (what kind)_____

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Are you satisfied with your smile? [] Yes [] No

Do you have any dental anxiety? (None) 1 2 3 4 5 6 7 8 9 10 (High)

Have you ever had your teeth straightened? [] Yes [] No
Have you had any unfavorable reaction associated with dental treatment? [] Yes [] No
If yes, please explain: _____

Have you been satisfied with your previous dental care? [] Yes [] No
If no, please explain: _____

Would you like to keep your natural teeth? [] Yes [] No
Have you ever been treated for Periodontal Disease (Gum Disease)? [] Yes [] No
Has anyone in your family ever been treated for Periodontal Disease? [] Yes [] No
Do you have any removable partials or dentures? [] Yes [] No

Please list all medications you take (prescription and over the counter, including vitamins, herbals & supplements:
_____
_____

Are you taking any of the following medications?
[] Nerve Pills [] Pain Killers (including aspirin) [] Muscle Relaxers [] Stimulants
[] Blood Thinners [] Tranquilizers [] Insulin [] Other(s): _____

Please list any other medical condition(s) you have or ever had:
_____

Are you allergic to any of the following?
[] Latex [] Penicillin/Amoxicillin [] Tetracycline [] Aspirin [] Dental Anesthetics
[] Others: _____
Do you use tobacco? [] No [] Yes – How Used? _____ How Much? _____ How Long? _____
Please rate your general health from 1-10: _____
Have you ever taken the drug Phen-fen and/or Redux? [] Yes [] No
For Women: Are you taking birth control pills? [] No [] Yes
* Antibiotics can make the pill ineffective for one month past month(s) of ingestion *
Are you pregnant? [] No [] Yes/How Long? _____ Are you nursing? [] No [] Yes

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires that payment in full for all services rendered at the time of visit. If account is not paid in full within 45 days of the date of service, regardless of insurance status, you will be responsible for interest charges, collection agency fees and any other expenses or legal fees incurred in collecting your account.

- I give authorization to the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or to aid in my treatment at any dental specialist to which I or the patient is referred.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information that I have provided.
- I give my permission to have my health discussed with my medical doctors of record that I have noted on this form.
- I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. Details available at the front desk.

Signature: _____ Date: _____

[] Adult Patient [] Parent or Guardian (print name) _____