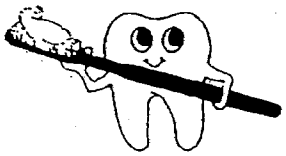

WELCOME TO
BEACHWOOD DENTAL ARTS

659 ATLANTIC CITY BOULEVARD, BEACHWOOD, NJ 08722 732-349-0555 (FAX) 732-349-0503

Patient Information

Patient Name: _____ Date: _____
(Last) (First) (MI) (Preferred Name)

Social Security #: _____ Birth Date: _____ Gender: _____ Marital Status: _____

Phone (Home): _____ Work: _____ Cell: _____ Best time to call: _____

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

Employer: _____ Employer's Address: _____ Employer's #: _____

Spouse's Name: _____ Birth Date: _____ SS#: _____

Spouse's Employer: _____ Employer's Address: _____ Employer's #: _____

IN CASE OF EMERGENCY, CONTACT: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO

Doctor's Name: _____ Phone#: _____

Specialist: _____ Phone#: _____

Have you ever had any of the following? Please check yes or no:

Yes	No		Yes	No		Yes	No	
☐	☐	Aids/HIV	☐	☐	Hepatitis - Type:	☐	☐	Stroke
☐	☐	Alcoholism/Drug Use	☐	☐	Herpes	☐	☐	Swollen Glands
☐	☐	Alzheimer's Disease	☐	☐	High Blood Pressure	☐	☐	Thyroid Problems
☐	☐	Arthritis/Rheumatism	☐	☐	Kidney Disease	☐	☐	Tonsillitis
☐	☐	Artificial Heart\Valves	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Artificial Joints	☐	☐	Low Blood Pressure	☐	☐	Tumors
☐	☐	Asthma	☐	☐	Mitro Valve Prolapse	☐	☐	Ulcers
☐	☐	Blood Disease/Anemia	☐	☐	Nervous Disorder	☐	☐	Venereal Disease
☐	☐	Cancer/Chemotherapy	☐	☐	Pacemaker	☐	☐	Vision Impairment
☐	☐	Diabetes - Type:	☐	☐	Parkinson's Disease			
☐	☐	Emphysema	☐	☐	Pins, Screws or Plates			Allergy Information
☐	☐	Epilepsy	☐	☐	Psychiatric Treatment	☐	☐	Local Anesthetic Allergy
☐	☐	Excessive Bleeding	☐	☐	Radiation Treatment	☐	☐	Sulfa Allergy
☐	☐	Fainting/Dizziness	☐	☐	Respiratory Problem	☐	☐	Latex Allergy
☐	☐	Glaucoma	☐	☐	Rheumatic Fever	☐	☐	Penicillin Allergy
☐	☐	Headaches	☐	☐	Scarlet Fever	☐	☐	Epinephrine
☐	☐	Hearing Impaired	☐	☐	Sinus Problems	☐	☐	Codeine
☐	☐	Heart Disease	☐	☐	Skin Rash	☐	☐	Other:
☐	☐	Heart Murmur	☐	☐	Stomach Problems			

Have you ever been admitted to a hospital or needed emergency care during the past two years? Explain: _____

Are you presently pregnant? ☐ Yes ☐ No Month _____ Nursing? ☐ YES ☐ NO

List all MEDICATIONS that you are currently taking: _____

Have you or are you now taking any medication for Osteoporosis ☐ Yes ☐ No

★ Do you pre-medicate before dental visits? ☐ Yes ☐ No

Do you take blood thinners? ☐ Yes ☐ No

If yes, please list name: _____

Do you take Aspirin? ☐ Yes ☐ No

Are you having a dental problem today? _____

Do you smoke? ☐ Yes ☐ No How much? _____

Date of last dental check-up: _____

- Do you feel that your teeth are important to your appearance? _____
- Do you like your smile? _____
- What would you change about your smile? _____
- Have you considered brightening your smile? _____

Insurance Information

Primary

Insurance Plan Name and Address: _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last) (First) (MI)

Insured's Birth Date _____ ID #: _____ Group #: _____

Insured's Address: _____
(Street) (City) (State) (Zip)

Insured's Employer's Name: _____

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

Patient's relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other _____

HIPPA CONSENT

I hereby acknowledge that I have received a copy of the Beachwood Dental Arts' Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative — Date

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

_____

Printed Name of Patient's Representative (if applicable)

Consent for Services

All emergency dental services, or any dental services performed, must be paid for in cash or credit card at the time services are performed.

WE REQUIRE 24 HOURS NOTICE FOR CANCELLATIONS. THERE WILL BE A CHARGE FOR APPOINTMENTS CANCELED WITHOUT SUFFICIENT NOTICE.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, the dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the free estimate listed for this dental care can only be extended for a period of one month from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I hereby authorize the Doctor, or his assignee to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian