BETAR DENTAL

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to complete this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date: _____ Home Phone: _____ Cell Phone: _____

Name: _____ Birthdate:_____ Social Security #: _____-____-_____
Last Name First Name Initial

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: ☐ Male ☐ Female Age: _____ Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single

Patient Employer: _____ Work Phone: _____ Who may we thank for your referral:_____

Emergency Contact Person: _____ Relationship: _____ Primary Phone: _____

Is it ok to release information to this person in case of an emergency? ☐ Yes ☐ No

Primary Care Physician: _____ Phone:_____ Date of Last Visit: _____

Medical Information

(Women) Are you pregnant? ☐ Yes ☐ No

Check ☒ if you have or had any of the following:

- ☐ AIDS
- ☐ Allergy-Aspirin
- ☐ Allergy-Latex
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Aspirin Therapy
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Circulatory Problems
- ☐ Convulsive Seizures
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart Problems

Describe_____

- ☐ Hemophilia
- ☐ Hepatitis (any type)
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer

Do you use alcohol? _____

Do you smoke? _____

Do you have any organ transplants or medical grafts? _____

Do you need antibiotics prior to dental procedures? _____

MEDICATIONS

List any medications you are currently taking:

_____

_____

_____

ALLERGIES TO MEDICATIONS

_____

_____

_____

Authorization

I authorize my insurance company to pay the dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use if this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges whether paid by or not paid by the insurance.

Signature_____ Date_____

Payment is due in full at the time of treatment unless prior arrangements have been approved.