David A. Beach, D.M.D., M.S., P.A.

Endodontics

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Cell _____

Occupation _____ Employed by _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Occupation _____ Phone _____

Referred by _____ Dentist's Name _____

What is the name of your dental insurance company? _____

Drivers License # _____

Person Financially Responsible _____

Financial Policy

The patient is responsible for any deductible and estimated co-payment at the time services are rendered. If you have dental insurance, the filing of your insurance clain is not a guarantee of payment. Your dental insurance is a contract between you and your insurance company. In the event a claim is not paid by the insurance company, you will be personally responsible for the remainder of the fees due. If the services of a collection agency are necessary to collect an unpaid balance, the undersigned agrees to pay all costs of collection including attorney's fees and court costs.

Patient's Signature _____ Date _____

(If a minor, parent or guardian must sign)

Emergency Contact _____ **Phone #** _____

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

HEALTH HISTORY

1.	AIDS	❑ Yes	❑ No	26. Liver Disease	❑ Yes ❑ No
2.	Alcohol/Drugs Addiction	❑ Yes	❑ No	27. Low Blood Pressure	❑ Yes ❑ No
3.	Anemia	❑ Yes	❑ No	28. Mitral Valve Prolapse	❑ Yes ❑ No
4.	Arthritis, Rheumatism	❑ Yes	❑ No	29. Nervous Problems	❑ Yes ❑ No
5.	Artificial Heart Valves	❑ Yes	❑ No	30. Pacemaker	❑ Yes ❑ No
6.	Artificial Joints	❑ Yes	❑ No	31. Psychiatric Care	❑ Yes ❑ No
7.	Asthma	❑ Yes	❑ No	32. Radiation Treatment	❑ Yes ❑ No
8.	Back Problems	❑ Yes	❑ No	33. Respiratory Disease	❑ Yes ❑ No
9.	Bleeding abnormally, with extractions or surgery	❑ Yes	❑ No	34. Rheumatic Fever	❑ Yes ❑ No
				35. Sinus Trouble	❑ Yes ❑ No
10.	Blood Disease	❑ Yes	❑ No	36. Stroke	❑ Yes ❑ No
11.	Cancer	❑ Yes	❑ No	37. Surgery	❑ Yes ❑ No
12.	Congenital Heart Lesions	❑ Yes	❑ No	38. Tonsillitis	❑ Yes ❑ No
13.	Diabetes	❑ Yes	❑ No	39. Tuberculosis	❑ Yes ❑ No
14.	Epilepsy	❑ Yes	❑ No	40. Tumor or growth on head or neck	❑ Yes ❑ No
15.	Fainting or dizziness	❑ Yes	❑ No		
16.	Headaches	❑ Yes	❑ No	41. Venereal Disease	❑ Yes ❑ No
17.	Heart Attack	❑ Yes	❑ No	42. Women:	
18.	Heart Murmur	❑ Yes	❑ No	Are you pregnant?	❑ Yes ❑ No
19.	Heart Problems	❑ Yes	❑ No	Due date _____	❑ Yes ❑ No
20.	Hepatitis Type _____	❑ Yes	❑ No	Are you nursing?	❑ Yes ❑ No
				43. Other	
21.	Herpes	❑ Yes	❑ No	_____	
22.	High Blood Pressure	❑ Yes	❑ No	_____	
23.	HIV Positive	❑ Yes	❑ No		
24.	Injury to head/neck	❑ Yes	❑ No		
25.	Kidney Disease	❑ Yes	❑ No		

MEDICATIONS

Do you have a medical condition which requires you to pre-medicate prior to dental treatment? ❑ Yes ❑ No

List medications you are currently taking:

ALLERGIES ❑ Yes ❑ No

❑ Latex ❑ Penicillin

❑ Aspirin ❑ Local Anesthetic

❑ Other _____

_____

_____

Pharmacy name _____ Phone _____

Note: A change in your health status should be reported to the office at the earliest possible time.

HIPPA Authorization

I authorize my doctor to retrieve and send all pertinent information to my general dentist.
I authorize the release of information to all my insurance companies as necessary.
I authorize the use of this form on all submissions.
I authorize my doctor to act as my agent in helping me obtain payment from any insurance company.
I authorize payment directly to my doctor.
I may receive a written copy of the Notice of Privacy Practices if desired.
I understand no information from my dental records will be released to anyone outside this office without my written permission.

Patient's Signature _____ Date _____

(If a minor, parent or guardian must sign)