Endodontic PROFESSIONALS

the root canal specialists

DAVID A. BEACH, D.M.D., M.S., P.A.

27605 Cashford Circle, Ste 101 • Wesley Chapel, FL 33544 • 813.907.8751

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? _____

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 claim 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 _____

*We accept credit cards, checks, debit cards, cash, HSA/FSA cards, and Care Credit as forms of payment. If paying by credit card, 2.3% will be added to cover the credit card fees and expenses incurred by the office. Other forms of payment will not incur the 2.3% additional cost.

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

ALLERGIES ☐ Yes ☐ No

☐ Latex ☐ Penicillin

☐ Aspirin ☐ Local Anesthetic

☐ Other _____

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:

_____

_____

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)