WELCOME

Dr. Richard L. Beckermeyer
D.D.S., PC

Patient Information & Health History

Thank you for coming in today. We're glad you're here! We look forward to listening to your needs that parallel a pathway to healthy smiles. Please take a few moments to inform us of your health background. If you have any questions, please don't hesitate to ask.

Last Name First Name

Home Phone Cell Phone Social Security #

Street Address

City State Zip Code

Birthday Email

Employer/School

Emergency Contact Phone

How did you hear about us?

Male ☐
Female ☐

Minor ☐

Marriage Status:
Married ☐
Single ☐
Other ☐

Primary Dental Plan

Primary Account Holder Relationship to Patient

Date of Birth Social Security # Phone

Address (if different) Employer Phone Occupation

Dental Plan Carrier Group# Subscriber#

Additional Third Party Payer (HSA, MSA, Secondary Dental Plan, etc.)

Primary Account Holder Relationship to Patient

Date of Birth Social Security # Phone

Address (if different) Employer Phone Occupation

Dental Plan Carrier Group# Subscriber#

Dental History

Reason for today's visit?

How often do you floss? How often do you brush?

Previous Dentist Email Phone Date of last dental visit? X-rays?

Have you had any problems with any of the following?

- ☐ Bad breath
- ☐ Grinding teeth
- ☐ Sensitivity to hot food
- ☐ Bleeding gums
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity to sweets
- ☐ Clicking or popping jaw
- ☐ Periodontal treatment
- ☐ Sensitivity when biting
- ☐ Food collects between teeth
- ☐ Sores or growths in your mouth
- ☐ Sensitivity to cold

Medical History

Physician's Name Phone Date of last visit?

Have you had any serious illnesses or operations? If Yes, please describe.

Are you required to take pre-medication for dental procedures?

Are you currently taking any medications? If yes, please list.

Have you ever had a condition not listed below? If yes, please describe.

Have you had any of the following conditions?

- ☐ Abdominal Bleeding
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Artificial Bones
- ☐ Artificial Heart
- ☐ Asthema
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart
- ☐ Failure
- ☐ Cosmetic Surgery
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ HIV + AIDS
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Psychiatric-Related
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ TMJ (Pain in Jaw Joint)
- ☐ Ulcers
- ☐ Venereal Disease

Do you smoke or use tobacco products?

☐ Yes ☐ No

Allergic to?

- ☐ Aspirin
- ☐ Codeine
- ☐ Anesthetic
- ☐ Erythromycin
- ☐ Milk Proteins
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other_____
- ☐ Jewelry
- ☐ Latex
- ☐ Metals

For Women Only

On Birth Control Pills?

☐ Yes ☐ No

Are you pregnant?

☐ Yes ☐ No

_____

If so, how many weeks?

Are you nursing?

☐ Yes ☐ No

Consent to Treatment

The undersigned consents to radiographs (x-rays), laboratory procedures, anesthesia, diagnostic tests, dental treatment, or other procedures rendered to the patient under the supervision of the Dr. Richard L. Beckermeyer D.D.S., PC. Although the undersigned may elect not to undergo certain specific procedures, without adequate diagnosis or treatment plan the dentist may decline to treat the patient.

Print Name **Sign Name** **Date**