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Doctors
Davis & Beyer
Dental Health Professionals
"Excellence by Choice"

www.venicedentist.com
records@venicedentist.com

PATIENT INFORMATION

DATE:

NAME: I PREFER TO BE CALLED:

ADDRESS: CITY: ST: ZIP:

HOME PHONE: WORK: CELL:

OTHER ADDRESS: CITY: ST: ZIP:

EMAIL:

DATE OF BIRTH AGE: SOCIAL SECURITY #:

PLACE OF BIRTH: STUDENT? ☐ YES ☐ NO

SEX: ☐ M ☐ F MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

PLACE OF EMPLOYMENT: OCCUPATION:

SPOUSE OR PARENT: EMPLOYER: PHONE:

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE? ☐ YES ☐ NO

WHOM MAY WE THANK FOR REFERRING YOU?

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

NAME: PHONE:

ADDRESS: CITY: ST:

DENTAL INSURANCE INFORMATION

Insurance Name:
Subscriber Name:
Subscriber DOB:
Subscriber ID#:
Insurance Phone #:

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Name:
Subscriber Name:
Subscriber DOB:
Subscriber ID#:
Insurance Phone #:

METHOD OF PAYMENT: I prefer to pay by: Check ☐ Cash ☐ Credit Card ☐

FINANCE CHARGE: *If I do not pay the entire New Balance within 25 days of the statement date a FINANCE CHARGE will be added to the account for the billing period. The FINANCE CHARGE will be periodic rate of 1% per month which is an ANNUAL PERCENTAGE RATE OF 12%. In case of default of payment I promise to pay any legal interest on the balance due, together with Any collection costs and reasonable attorney fees incurred to effect collection of this account.*

APPOINTMENTS: *Please be advised 24 hours notice must be given if a cancellation is absolutely necessary, otherwise you will be charged a cancellation fee of $50 for each appointment cancelled.*

AUTHORIZATION: *I hereby authorize payment directly to Davis & Beyer Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer medications, perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I certify that the above information & medical history is true and correct to the best of my knowledge.*

Patient Signature:

Please Continue Filling Out Your Information On The Other Side Of This Form

DENTAL INFORMATION

What is the reason for your dental visit today?

Would you like to improve your smile? Yes ☐ No ☐

If so, what is the first condition you would like doctor to address:

Please answer these questions:	YES	NO	NOTES
Do your gums bleed when you brush or floss?			
Are your teeth sensitive to cold, hot, sweets or pressure?			
Does food or floss catch between your teeth?			
Is your mouth dry?			
Have you had any periodontal (gum) treatments?			
Have you ever had orthodontic (braces) treatment?			
Have you had any problems associated with previous dental treatment?			
Is your home water supply fluoridated?			
Do you drink bottled or filtered water?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?			
Do you have earaches or neck pains?			
Do you have any clicking, popping or discomfort in the jaw?			
Do you brux or grind your teeth?			
Do you have sores or ulcers in your mouth?			
Do you wear dentures or partials?			
Do you participate in active recreational activities?			
Have you ever had a serious injury to your head or mouth?			

Date of your last dental exam: Previous Dentist:

Date of last dental x-rays?

What was done at that time?

HEALTH HISTORY

To our patients: Although dentists primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care, that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

	Yes	No
Height _____ Weight _____ Are you in good health?	☐	☐
Have there been any changes in your general health in the past year?	☐	☐
Are you under the care of a physician? Date of last visit _____	☐	☐
If so, for what are you being treated? _____		
Have you had any illness, operation or been hospitalized in the past five years?	☐	☐
Do you have unhealed/recurrent injuries, inflamed areas, growths or sore spots in or around your mouth? *If so, describe where* _____	☐	☐
Do you have a prosthetic joint/implant? *If so, describe where* _____	☐	☐
Have you ever had a heart valve replacement or vascular graft?	☐	☐

Name of Surgeon _____ Telephone # _____

HEART/CIRCULATORY CONDITIONS

	YES	NO	NOTES
Rheumatic fever?	☐	☐	
Damaged heart valves / mitral valve prolapse?	☐	☐	
Heart murmur?	☐	☐	
High blood pressure?	☐	☐	
Low blood pressure?	☐	☐	
Chest pain / angina?	☐	☐	
Heart attack(s)?	☐	☐	
Irregular heart beat?	☐	☐	
Cardiac pacemaker?	☐	☐	
Heart surgery?	☐	☐	
Blood transfusion?	☐	☐	
Blood disorder such as anemia?	☐	☐	
Bruise easily?	☐	☐	
Bleeding tendency / abnormal bleed?	☐	☐	

LUNG CONDITIONS

	YES	NO	NOTES
Bronchitis, chronic cough?	☐	☐	
Asthma?	☐	☐	
Hay fever / sinus problems?	☐	☐	
Snoring / sleep apnea?	☐	☐	
Difficult breathing / other lung trouble?	☐	☐	
Tuberculosis?	☐	☐	
Emphysema or COPD?	☐	☐	
Do you smoke?	☐	☐	
Do you use chewing tobacco?	☐	☐	

OTHER CONDITIONS

	YES	NO	NOTES
Cancer/radiation therapy/chemotherapy?	☐	☐	
Type of cancer?	☐	☐	
Diabetes? Circle: Type I Type II	☐	☐	
Low blood sugar?	☐	☐	
Gallbladder trouble?	☐	☐	
Kidney trouble?	☐	☐	
Are you on dialysis?	☐	☐	
Dementia, Alzheimer's disease	☐	☐	
Fainting spells?	☐	☐	
Convulsions / epilepsy?	☐	☐	
Stroke?	☐	☐	
Thyroid trouble?	☐	☐	
Are you immunosuppressed? possibly from transplant surgery, etc.	☐	☐	
Problems with the immune system? possibly from medication / surgery, etc.	☐	☐	
Hepatitis, jaundice, or liver disease?	☐	☐	
Stomach ulcers?	☐	☐	
Contagious diseases?	☐	☐	
Sexually transmitted diseases?	☐	☐	
Swollen ankles, arthritis or joint disease?	☐	☐	
Delay in healing?	☐	☐	
Chronic fatigue / night sweats?	☐	☐	
ADD / ADHD?	☐	☐	
A history of drug abuse?	☐	☐	
Do you drink alcohol?	☐	☐	

HEALTH HISTORY

MEDICATION INFORMATION

	YES	NO	NOTES
Any kind of medication, drug, pills?			
Have you or are you currently taking an oral or intravenous bone density or bisphosphonates including but not limited to: Prolia, Zometa, Aredia, Fosamax or Actonel? (Please Circle)			
Blood thinners (Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, Aspirin, Vitamin E, Ginko Biloba)? *Please Circle*			
Are you taking diet pills?			
Any natural product, herbal supplement or homeopathic remedy?			
Have you ever taken tranquillizers, sleeping pills, anti- depressants, and/or narcotics on a regular basis? If so, please list:			

ALLERGY INFORMATION

Are you allergic to:	YES	NO	NOTES
Latex?			
Local or topical anesthesia?			
Penicillin?			
Clindamycin?			
Sulfa Drugs?			
Codeine or other narcotics?			
Other antibiotics?			
Other medication?			

CURRENT MEDICATIONS

Please list all medications and supplements:

Preferred pharmacy: Pharmacy phone number:

THIS SECTION IS FOR WOMEN ONLY. WOMEN, CONTINUE ON WHEN YOU HAVE COMPLETED THIS SECTION.

Is there a possibility of pregnancy? ❑ Yes ❑ No Expected delivery date:

Are you nursing? ❑ Yes ❑ No Are you taking birth control pills? ❑ Yes ❑ No

Women Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills.
Consult your physician / gynecologist for assistance regarding additional methods of birth control.

NOTES:

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: x **Reviewed by:** x **Date:** x

Thank you for making us smile by taking care of your smile!