Patient Registration Form

Beavercreek Dental

Patient Information (Confidential)

Name: _____ Preferred Name: _____
Address: _____ City _____State _____ ZIP _____
Cell Phone _____Home Phone _____
Work Phone _____ Is it Ok to call your work? Yes or NO
Is it Ok to leave detailed messages on your phone? Yes or NO

IN CASE OF EMERGENCY CONTACT (*specify someone who does not live in your household*)
Name_____ Relationship_____
Cell/Home Phone _____ Work Phone _____

Soc. Sec. # _____ Birth Date _____ Age _____
Email:_____ SEX: Male _____ Female _____
Check Appropriate Answer: **Minor _____ Single _____ Married _____ Partnered_____**

Whom may we thank for referring you? _____

Dental Insurance: Yes ___ No ___ **SELF PAY:** Cash ___ Check ___ Credit Card___

Primary Dental Insurance Company: _____
Employer: _____ Insurance ID# _____Group # _____
Insured Birthday:_____ Relationship to you: Self ___Spouse___Parent___ Other_____

Secondary Dental Insurance Company: _____
Employer: _____ Insurance ID# _____Group # _____
Insured Birthday:_____ Relationship to you: Self ___Spouse___Parent___ Other_____

Physician's Name:_____Phone # _____
Date of Last Physical Exam _____

Previous Dentist:_____ Date Of Last Dental Exam _____
Phone # _____

Dental Health History

Have you ever used bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva? Y/ N

Please *CIRCLE* YES or NO if you have had any of the following:

AIDS/HIV Yes or NO
Anemia Yes or NO
Rheumatic/Scarlet Fever Yes or NO
Artificial Heart Valve Yes or NO
Artificial Joints Yes or NO
Asthma Yes or NO
Back Problems Yes or NO
Bleeding Abnormally Yes or NO
Epilepsy Yes or NO
Fainting or Dizziness Yes or NO
Shortness of breath Yes or NO
Respiratory Disease Yes or NO
Glaucoma Yes or NO
Blood Disease Yes or NO
Cancer Yes or NO
Radiation Yes or NO
Diabetes Yes or NO
Emphysema Yes or NO
Heart Murmur Yes or NO
Heart Problems Yes or NO
Venereal Disease Yes or NO
Hepatitis Type _____ Yes or NO
Herpes Yes or NO
High Blood Pressure Yes or NO
Jaw Pain Yes or NO
Kidney Disease Yes or NO
Liver Disease Yes or NO
Low Blood Pressure Yes or NO
Mitral Valve Prolapsed Yes or NO
Nervous Problems Yes or NO
Pacemaker Yes or NO
Psychiatric Care Yes or NO
Sinus Trouble Yes or NO
Stroke Yes or NO
Swollen Feet/Ankles Yes or NO
Swollen Neck Glands Yes or NO
Thyroid Problems Yes or NO
Tonsillitis Yes or NO
Tuberculosis Yes or NO
Tumor or Growth on head or neck Yes or NO
Ulcer Yes or NO
Weight Loss, unexplained Yes or NO

Are you allergic to any medications? YES OR NO
Please List: _____

Please list any drugs you are presently taking:

_____

_____

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Kim all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent or Guardian:_____
Print Name: _____ **Date:** _____