853 Medical Drive, Suite 112
Wentzville, MO 63385
p: 636.487.0122 ▪ f: 636.487.0124
e: info@BeaconRootCanal.com ▪ w: BeaconRootCanal.com

Date: ____________________

PATIENT INFORMATION

Have you ever been a patient of our practice? ☐ Yes ☐ No

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name ____________________ M.I. ______ Last Name ____________________

Gender: ☐ M ☐ F Birth Date ______________ Age ______ SSN ____________________ Nickname ______________

Address ______________________________ Apt ______ City ____________________ State ______ Zip ______________

Home Ph # ____________________ Cell Ph # ____________________ Email ______________________________

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

☐ SELF **(skip this section)** ☐ Spouse ☐ Parent/Guardian ☐ Other (specify) ______________________________

Name ______________________________ Birth Date ______________ Age ______ SSN ____________________

Drivers Lic # ____________________ State ______ Home Ph # ____________________ Cell Ph # ____________________

Address ______________________________ Apt ______ City ____________________ State ______ Zip ______________

Employer ______________________________ Work Ph # ____________________ Ext. ______

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Employer ______________________________

Plan ______________ ID# ____________________

Ins. Co. Name ______________________________

Address ______________ City ______________

State ______ Zip ______ Tel. ______________

Group# ______________ Group Name ______________

Insured Party ______________ Relation ______________

Sex: ☐ M ☐ F Birth Date ______________ SSN ______________

Address ______________ City ______________

State ______ Zip ______ Tel. ______________

SECONDARY DENTAL INSURANCE

Employer ______________________________

Plan ______________ ID# ____________________

Ins. Co. Name ______________________________

Address ______________ City ______________

State ______ Zip ______ Tel. ______________

Group# ______________ Group Name ______________

Insured Party ______________ Relation ______________

Sex: ☐ M ☐ F Birth Date ______________ SSN ______________

Address ______________ City ______________

State ______ Zip ______ Tel. ______________

Do we have permission to send you text messages to your cell phone # listed above? ☐ Yes ☐ No

Do we have permission to use the email listed above for office communications, including billing statements? ☐ Yes ☐ No

FEES & PAYMENTS: Beacon Endodontics makes every effort to keep the cost of your care low. Payment is due at the time of service. Other arrangements can discussed with the office manager for extenuating circumstances. You will be provided an estimate of the charges for your treatment. If you have any dental and/or medical insurance we will be glad to file on your behalf, please ensure you have provided the proper information on this form. ***REMINDER****: Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for procedures and others pay a percentage of the charge.* ***It is your responsibility to pay any deductible amount, co-insurance or any other balance not covered by insurance.*** You will be responsible for all collection costs, attorney fees, and court costs.

MY SIGNATURE BELOW authorizes release of information, including treatment and protected health information to my insurance company required to process payment for services. I authorize my insurance carrier to pay benefits for services rendered, directly to Beacon Endodontics. I have read and agree to the terms of the above information. I understand payment is due at the time of service and I am responsible for any balance. **I hereby acknowledge that a copy of this office's Notice of Privacy Practices is available to me and I have been given the opportunity to ask any questions I may have regarding this Notice.**

X____ X______________________

Signature of Patient (Parent or Guardian if Minor) **Date**

853 Medical Drive, Suite 112
Wentzville, MO 63385
p: 636.487.0122 ▪ f: 636.487.0124
e: info@BeaconRootCanal.com ▪ w: BeaconRootCanal.com

PATIENT INFORMATION

Date: ____________________

First Name ______________________________ Last Name ______________________________

Nickname ______________________________ Gender: ☐ M ☐ F Birth Date ______________________________

DENTAL HISTORY

Reason for today's visit ____

____________________________ Are you in pain? ☐No ☐Yes ⇨ For how long? ____________________________

Who is your dentist? ____________________________ How did you how hear about us? ____________________________

MEDICAL HISTORY

Date of last physical exam ________________ How would you describe your health? ☐Excellent ☐Good ☐Poor

Have you been directed to take a pre-medication before dental treatment? ☐Yes ☐No

Have you had any illness, operation, or been hospitalized in the past two years? ☐Yes ☐No

Are you now, or have you ever used, a bisphosphonate (Actonel, Boniva, Fosamax, Reclast)? ☐Yes ☐No

Are you on a blood thinner or a daily aspirin? ☐Yes ☐No

Have you ever had: Periodontal treatment? ☐Yes ☐No A night guard? ☐Yes ☐No Teeth ground / bite adjusted? ☐Yes ☐No

Please check any of the following that apply to your medical history:

BONE
- ☐ Arthritis
- ☐ Osteonecrosis
- ☐ Osteoporosis / Osteopenia

BLOOD DISORDERS
- ☐ Anemia
- ☐ Blood disease / disorder
- ☐ Circulatory problems
- ☐ Hemophilia
- ☐ HIV
- ☐ Sickle cell disease

EARS / EYES / HEAD
- ☐ Seizures / Epilepsy
- ☐ Dementia
- ☐ Glaucoma
- ☐ Headaches / Migraines
- ☐ Head injury
- ☐ Jaw pain / popping
- ☐ Sinus trouble

HEART
- ☐ Arterial stent
- ☐ Artificial heart valve(s)
- ☐ Chest pain

If so, when ________________
- ☐ Congenital heart condition
- ☐ Heart attack(s)

If so, when ________________
- ☐ Heart condition
- ☐ Heart surgery

If so, when ________________
- ☐ Heart valve damage
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Pacemaker

ONCOLOGY / CANCER
- ☐ Cancer

If so, type ________________

Year: ________________
- ☐ Chemotherapy/Radiation

If so, when ________________

ORTHO/ BONES/ JOINTS
- ☐ Joint replacement

If so, when ________________
- ☐ Back problems
- ☐ Cortisone treatments

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema
- ☐ Hay fever
- ☐ Pneumonia/bronchitis/chronic cough
- ☐ Respiratory problems
- ☐ Tuberculosis

THYROID
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Thyroid surgery

OTHER
- ☐ Alcoholism
- ☐ Cold sores/fever blisters
- ☐ Smoker/Tobacco user

- ☐ Diabetes
- ☐ Dialysis
- ☐ Dizziness/fainting
- ☐ Acid reflux / Ulcers
- ☐ GI troubles/IBS/colitis
- ☐ Hepatitis (A, B, C)
- ☐ Immune system deficiency *(including surgery / meds)*
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Low blood sugar
- ☐ Substance abuse
- ☐ Prosthetic implants
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Special diet
- ☐ Stroke / TIA
- ☐ Swelling
- ☐ Venereal disease

Are you under the care of a physician for any of the conditions listed? ☐Yes ☐No; if Yes, explain ____________________________

____

Do you have any health issues or conditions that need further clarification? ☐Yes ☐No; if Yes, explain ____________________________

____

____

853 Medical Drive, Suite 112
Wentzville, MO 63385
p: 636.487.0122 ▪ f: 636.487.0124
e: info@BeaconRootCanal.com ▪ w: BeaconRootCanal.com

MEDICATIONS

Please list any medication(s) or supplement(s) (including natural, herbal, or homeopathic products) you are taking:

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

ALLERGIES

Please check any of the following that you are allergic to: ☐ **NO ALLERGIES**

ANTIBIOTICS	OTHER MEDS	OTHER MEDS	OTHER ALLERGIES
☐ Amoxicillin	☐ Acetaminophen	☐ Hydrocodone	☐ Latex
☐ Cephalexin	☐ Aspirin	☐ Local anesthetics	☐ Metals (Nickel, Mercury, etc.)
☐ Erythromycin	☐ Barbiturates	☐ Oxycodone	☐ Nuts
☐ Keflex	☐ Codeine	☐ Sulfa Drugs	Other ______________
☐ Penicillin	☐ Epinephrine	☐ Valium	______________
☐ Clindamycin	☐ Ibuprofen	☐ Iodine	______________

Please list any other medication you are allergic to: ______________________________

WOMEN ONLY

NOTICE: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician regarding additional methods of birth control.*

Are you pregnant or trying to get pregnant? ☐Yes ☐No Expected delivery date: ______________________

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

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 doctor, or any other member of the Beacon Endodontics staff, responsible for any errors or omissions that I have made in the completion of this form.

X____ **X**____________________

Signature of patient (Parent or Guardian if Minor) **Date**