BEACON ENDODONTICS

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

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 _____

☆**Do we have permission to send you text messages to your cell phone number?** ☐ Yes ☐ No

☆**Do we have permission to use your email for office communications, including billing statements?** ☐ Yes ☐ No

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. _____

PRIMARY DENTAL INSURANCE

Insurance Company _____

Employer _____

Subscriber # _____

Group or Plan # _____

Subscriber _____ Relation _____

Birth Date _____ SSN _____

SECONDARY DENTAL INSURANCE

Insurance Company _____

Employer _____

Subscriber # _____

Group or Plan # _____

Subscriber _____ Relation _____

Birth Date _____ SSN _____

FEES & PAYMENTS: Beacon Endodontics makes every effort to keep the cost of your care low. Payment is due at the time of service. You will be provided an estimate of the charges for your treatment. If you have dental 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 confirm network participation, 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**

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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? ☐Yes ☐No; if Yes, explain _____

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

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MEDICATIONS

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

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

PREFERRED PHARMACY

Name _____ Phone Number _____

Address, City, State, Zip _____

EMERGENCY CONTACT

Who would you like us to call in case of an emergency?

Name & Phone Number _____

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	☐ NSAIDs (e.g., 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 Due 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 responses to these questions have been answered to my satisfaction. I will not hold the 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**