

Michael D. Beck, DDS, PC
General Dentistry ~ A Professional Corporation

GENERAL PATIENT INFORMATION

Today's Date _____

Patient's Name _____ Date of Birth _____

Street Address _____ City _____ Zip _____

Home Phone _____ Alternate Phone _____ Email _____

Texas Drivers License Number _____ Social Security Number _____

Marital Statue (circle one) Single Married Divorced Widowed

Is patient a full time college student with insurance? Y N School _____

Spouse's Name _____ Referred By _____

Other Family Treated by Dr. Beck _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

SAME AS ABOVE

Name _____ Date of Birth _____

Address _____ City _____ Zip _____

Home Phone _____ Relationship to Patient _____ SS# _____

EMPLOYMENT INFORMATION

Employer (responsible person) _____ Phone _____

Address _____ City _____ Zip _____

Employer (spouse) _____ Phone _____

Address _____ City _____ Zip _____

DENTAL INSURANCE INFORMATION

Employee (policy owner) _____

Employee ID# _____ Employee Date of Birth _____ Employee SS# _____

Employer Name _____ Group # _____

Insurance Company Name _____

Address _____ City _____ St _____ Zip _____

Person To Contact _____ Phone (____) _____ - _____ Ext _____

If you have secondary or additional dental insurance, complete the back of this form.

SECONDARY INSURANCE INFORMATION

Insured Employee (policy owner) _____ Owner SS# _____
Employer Plan Name _____ Group # _____
Insurance Company Name _____ Policy # _____
Address _____ City _____ St _____ Zip _____
Person To Contact _____ Phone (____) _____ - _____ Ext _____

DO NOT WRITE BELOW THIS LINE

PRIMARY INSURANCE

DATE

POLICY OWNER

EFF DATE

SOC SEC #

GROUP #

INS PHONE #

PATIENT

SPOKE TO

DEDUCTIBLE

YEAR MAX

PREVENTATIVE

BASIC

MAJOR

NOTES

SECONDARY INSURANCE

DATE

POLICY OWNER

EFF DATE

SOC SEC #

GROUP #

INS PHONE #

PATIENT

SPOKE TO

DEDUCTIBLE

YEAR MAX

PREVENTATIVE

BASIC

MAJOR

NOTES

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PATIENT MEDICAL/DENTAL INFORMATION

Today's Date: _____

General Physician _____
 Phone _____
 Last Exam _____
 Specialty Physician _____
 Phone _____
 Last Exam _____

1. Purpose of this Dental Visit? _____
 2. Are you under medical treatment now? Y N
 3. Are you taking any medications now? Y N
 Please List: _____

4. Your age? _____
 5. Do you use tobacco? Y N
 6. Women: Are you pregnant? Y N
 Are you nursing? Y N
 Do you take birth control pills? Y N
 7. Are you allergic to:
 Penicillin or other antibiotics? Y N
 Codeine or other pain medicine? Y N
 Aspirin? Y N
 Local Anesthetics? Y N
 Others? Please List Y N

8. Do you have or have you had any of the following?
Please circle each answer individually!

- High Blood Pressure Y N
- Heart Attack Y N
- Heart Trouble Y N
- ◆ Rheumatic Fever Y N
- ◆ Mitral Valve Prolapse Y N
- Swollen Ankles Y N
- Fainting/ Seizures Y N
- Asthma Y N
- Low Blood Pressure Y N
- Epilepsy/Convulsions Y N
- ◆ Leukemia Y N
- Diabetes Y N
- Kidney Disease Y N
- ◆ AIDS or HIV Y N
- Thyroid Problem Y N
- Easily Winded Y N
- Herpes/Shingles Y N
- Hay Fever/Allergies Y N
- ◆ Radiation/Chemo Therapy Y N
- Recent Weight Loss Y N
- Respiratory Problem Y N

- Heart Disease Y N
- Cardiac Pacemaker Y N
- ◆ Stents Y N
- ◆ Heart Murmur Y N
- Angina Y N
- Frequently Tired Y N
- Anemia Y N
- Emphysema Y N
- ◆ Cancer Y N
- Arthritis Y N
- ◆ Heart Valve Replacement Y N
- ◆ Joint Replacement Y N
- Hepatitis Y N
- S T D Y N
- Stomach Trouble/Ulcers Y N
- Chest Pains Y N
- Stroke Y N
- Tuberculosis Y N
- Glaucoma Y N
- Liver Disease Y N
- Other? Please List: Y N

◆ Conditions may require an antibiotic before treatment

9. Dental Questions

- Do your gums bleed when you brush or floss? . . . Y N
- Are your teeth sensitive to hot or cold? Y N
- Are your teeth sensitive to sweet or sour? Y N
- Do you feel pain in any of your teeth? Y N
- Do you have any swelling in you mouth? Y N
- Have you had any head, neck or jaw injuries? . . . Y N
- Do you have difficulty chewing? Y N
- Do you have frequent headaches? Y N
- Do you clench or grind your teeth? Y N
- Have you had problems with past extractions? . . . Y N
- Have you had any orthodontic work (braces)? . . . Y N
- Do you bleed excessively after extractions? Y N
- Do you have mouth ulcers/fever blisters? Y N

OFFICE POLICY

All patients are expected to pay in full on each visit unless other arrangements have been approved. If you have dental insurance, we will determine, APPROXIMATELY, what your portion of the payment will be and ask for that amount at each visit. Any balance remaining after your insurance pays is your responsibility.

I certify that the above information is accurate to the best of my knowledge and that I have read and accept the above Office Policy.

_____ **Signature**

I have reviewed my health information on the opposite side of this page and have made any needed changes to it in order to update my current medical and dental status.

Patient's signature

sign below

Date

→ 1 _____

→ 2 _____

→ 3 _____

→ 4 _____

If there are significant changes in your health history or if it has been too long since this form was updated or if you have completed all the updates above, you may be asked to complete a new form.

A complete and accurate health history is an important part of our care for you.

Thank you for your cooperation.

Dr. Beck