Welcome To Our Office *Michael Beke, DMD*

Who may we thank for this referral? _____

Name: _____ Preferred Name: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone: _____Ext: _____ Cell Phone: _____
__ Married __ Single __Male __ Female Age: _____ Birthdate: _____ Social Security #: _____
E-mail: _____

Person Responsible for Account (if other than above): _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone: _____Ext: _____ Cell Phone: _____
__ Married __ Single __Male __ Female Age: _____ Birthdate: _____ Social Security #: _____
Employer's Name: _____ Employer's Phone: _____
Employer's Address: _____ City: _____ Zip: _____

Primary Dental Insurance Coverage __ No Insurance
Subscriber's Name: _____ Birthdate: _____ Social Security #: _____
Relationship to Subscriber: __ Self __ Spouse __ Child __Other
Name of Insurance Carrier: _____
Insurance Carrier Phone: _____ Group #: _____ ID #: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses/disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. _____ **Initial**

I give my permission to have my name or the names of my dependent family members on the computer schedule. _____ Initial
I give my permission to be reminded of my/our appointments via email, text, or phone message reminders. _____ Initial
I authorize the release of photos and X-rays and phone numbers for referrals and professional use as needed. _____ Initial
I authorize the release of my dental health and information to immediate family members/account guarantor. _____ Initial

OFFICE POLICIES

For your convenience, we will confirm your appointments by email, phone or text. **A 48 hour (two working days) notice of schedule changes will be necessary to avoid a $75.00 late cancellation fee. _____Initial**
The financial obligation for your dental treatment is due the same day treatment is provided. The patient co-pay information that we provide to you is based upon contract information provided to us by your insurance carrier and in no way guarantees payment. Any unpaid insurance monies for your treatment will then become your responsibility.
Billing your insurance carrier is a courtesy provided to you by this office. We will make every attempt to collect payments in a timely manner. If, however, insurance monies haven't been received after 90 days of treatment, the balance is therefore your responsibility and all insurance monies for that treatment will be sent to you from your carrier.

Patient Name: _____ Date: _____
Signature: _____
Relationship to Patient: _____
Dependent family members also covered by this acknowledgement:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

__The patient refused to sign __ Communication Barriers __ Emergency Situation __ Other

Medical History

Name of Physician: _____ Date of Last Exam: _____

Estimate of Your General Health: __ Poor __Fair __ Good Current Weight: _____

Check if you have, or ever had the following:

__ Asthma, Hay Fever, or other Allergies _____
__ Allergy to Penicillin, Aspirin, Local Anesthetic, Codeine, Fluoride or Other Drugs
__ Blood pressure, Heart Problems or Stroke
__ Rheumatic Fever or Heart Murmur
__ Pacemaker or Open Heart Surgery
__ Diabetes, Liver, Kidney, Thyroid, or Lung Problems_____
__ Ulcers or Stomach Problems
__ GERD or Gastrointestinal Disorder
__ Epilepsy or Nervous Disorders
__ Arthritis
__ Radiation Treatments or Chemotherapy
__ Male-Prostate Disorders
__ Anemia, Bleeding or Clotting Disorders
__ Herpes
__ HIV
__ Hepatitis -which type_____
__ Artificial Prosthesis
__ Emotional Problems/diagnosed Depression
__ Alcohol/Drug Dependency
__ Smoker – number of years _____
__ Contact Lenses or Glaucoma
__ Female – Pregnant? Due Date _____
__ Female – Nursing Mother?
__ Female – Taking Birth Control Pills

Are you required to Pre-Medicate before dental treatment? No Yes
List any current medication taken: _____
List any medication taken within the last 2 years: _____
Are you taking Tagamet (Cimetidine)? No Yes If Yes, which ones? _____
Are you taking any herbal supplements/medicines? No Yes If Yes, which ones? _____
Do you take antacids? No Yes If yes, how often? _____

Do you snore? No Yes
Have you ever been told that you gasp for air or suddenly stop breathing while sleeping? No Yes
Have you ever been diagnosed with Sleep Apnea? No Yes If yes, have you used a CPAP? No Yes
Have you ever had an overnight sleep study? No Yes

Dental History

Name of Previous Dentist: _____ Last Exam: _____ Last X-rays: _____
Reason for Seeking Treatment: _____
Check if you have, or ever had the following:

__ Unhappiness with the appearance of your teeth
__ Unfavorable dental experiences or dental fears
__ Problems with the effectiveness or bad reaction to dental anesthetic
__ Orthodontic treatment (braces) When? _____
__ Periodontal (gum) treatment. When? _____
__ Bleeding gums
__ Sensitivity to temperature in any part of your mouth
__ A burning sensation in your mouth
__ Painful teeth
__ Difficulty swallowing
__ An unpleasant taste or odor in your mouth
__ TMJ (jaw) problems
__ Noises in your jaw during opening or closing
__ Difficulty opening your mouth widely
__ Stiff neck muscles or tension headaches
__ Clenching or grinding teeth during night or day
__ Loss of any teeth
__ Complete or partial denture

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Signed: _____ Date: _____

Doctor Signature: _____ Date: _____

Office Use Only

ASA: I II III IV

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