



Beavercreek Dental
 19029 S. Beavercreek Rd
 Oregon City, OR 97045
 (503)722-9184

Medical Alert For Office Use

Thank you for visiting Beavercreek Dental. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

CITY STATE ZIP

Employer _____ Drivers License _____

Birth date _____ Height _____ Weight _____

Phone: Home (____) _____ Social Security # _____

Work (____) _____ May we contact you at work? Yes No

Mobile(____) _____ Male Female

Emergency: Name _____ Phone (____) _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier (United Concordia, Cigna PPO, MetLife, United Concordia, Delta Premiere, Delta Dental of AZ, Only)

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ **Date** _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

CITY STATE ZIP

Telephone (____) _____

Other Information

How did you hear about us? _____

What was the reason for today's visit? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

What did you like most about your last dentist? _____

Medical History and Information

Conditions

- | | |
|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Facial Surgery | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> HIV+ Aids | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ulcers |

Allergies

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulfa
- Tetracycline

Other _____

Y N

- Do you Smoke
or use Tobacco?

If Female

Y N

- Are you taking Birth
Control Pills?
 Are you pregnant?
If yes, # of weeks _____
 Are you Nursing?

Please list any medications
you are currently taking: _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

PATIENTS SIGNATURE

DATE

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE

DATE