Beverly D Deacon D.D.S

Patient Registration and Medical History

About You:

Date: _____/_____/_____
Whom May We Thank for Referring You: _____
Patient Name:_____
Last First MI
Preferred Name: _____ □ Male □ Female
Mailing Address: _____
_____
Home #: _____ Work #: _____
Cell #: _____ E-Mail: _____
Birthdate: _____/_____/_____ Age:_____
SS #: _____-_____-_____ Occupation: _____
Employer: _____ How Long: _____
Employer Address: _____
Status: □ Single □ Marriec □Other □ Minor
Spouse's Name: _____
Spouse's Birthdate: _____/_____/_____
Children's Ages: _____

Emergency Contact:

Whom should we contact? _____ Relation: _____
Home Phone #: _____ Work Phone #: _____
Cell Phone #: _____

Insurance Info:

Primary Dental Insurance
Company Name: _____
Claims Address: _____
Phone #: _____
Insured's Name: _____
Relation: _____ Date of Birth: _____/_____/_____
Primary Insured's ID #: _____
Group Plan #: _____
Employer Name: _____

Dental Info:

Previous dentist name-_____ Phone number- _____
Date of Last Dental Visit _____
Reason for today's visit: □ Exam □ Cosmetic Consult □ Emergency
Please indicate any of the following concerns:

□ Stained/ Yellow Teeth
□ Chipped Teeth
□ Gaps Between Teeth
□ Crooked Teeth
□ Heavy Snoring
□ Sleep Apnea
□ Wear Sleep Device
□ Sensitive Teeth/ Gums
□ Lost/ Broken Fillings
□ pain with hot/ cold/ biting
□ Tooth keeps you up at night
□ Popping/ Clicking Jaw
□ Grind/ Clinch Teeth
□ Locking Jaw
□ Tender Bleeding Gums
□ Loose Teeth
□ Bad Breath/ Taste
□ Tooth Brush: Soft __ Med __ Hard __
□ How would you rate your smile (worst) 1 2 3 4 5 6 7 8 9 10 (best)
□ Hard to get numb

Medical Concerns:

Who is your medical doctor? _____
Medical Docotor's Phone number: _____
The date of your last physical: _____/_____/_____
Pharmacy Name Phone #
Have you ***ever*** had or currently have any of the following:

Y / N Heart Attack/Stroke
Y / N Heart Surgery/ Pacemaker
Y / N Heart Stent
Y / N Congestive Heart Failure
Y / N Artificial Valves
Y / N Heart Disease
Y / N Chest Pains
Y / N Emphysema
Y / N Chemo Therapy
Y / N Radiation Treatment
Y / N Hepatitis
Y / N HIV+/AIDS/ARC
Y / N Arthritis/ Rheumatism
Y / N Artificial Bones/Joints
Y / N Fainting/ Seizures/ Epilepsy
Y / N Cold Sores
Y / N Severe/ Frequent Headaches
Y / N Frequent Neck Pain
Y / N Back Problems
Y / N Diabetes
Y / N High/ Low Blood Pressure
Y / N Bleeding Problems
Y / N Thyroid Problem
Y / N Kidney Problem
Y / N Liver Problem
Y / N Asthma
Y / N Sinus Problem
Y / N Nervousness
Y / N Tuberculosis (TB)
Y / N Venereal Disease
Y / N Alcohol/Drug Abuse
Y / N Tobacco Use _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what_____
_____
Have you ever responded adversly to medical or dental treatment? _____
Are you taking any medication at this time? _____ If so what _____
_____
Are you currently under the care of a physician? □ Yes □ No
For what conditions? _____
(Women) Do you suspect that you are pregnant? □ Yes □ No Are you nursing □ Yes □ No
Is there anything else that we should know about your medical history?
_____
The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____/_____/_____ _____
Date Signature

_____/_____/_____ _____
Date Dentist's Signature

Account Info:

Person Responsible for the Account:
Name: _____ Relation: _____
Billing Address: _____
SS#: _____/_____/_____ Drivers License #: _____
Work/ Cell #: _____
Pmt Method: □ Cash □ Check □ CC # _____ EXP-_____

Assignment And Release:

I, the undersigned, have insurance with _____
and assign directly to Dr. Beverly D. Deacon all benefits, if any,
otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date Signature

Financial / Appointment Consent:

For _____ (patient Name)
We welcome you and your family to Dr. Beverly Deacon's office. We look forward to providing you with the most exceptional dental care. To provide you with the most beneficial and comprehensive service and care, we do ask that you review and complete our office and financial policy consent forms. We will gladly discuss your proposed treatment, financial options and any other questions you may have. We strive to keep you informed and involved with your treatment as much as possible.

Dental Insurance:

_____ (initials): I/We **DO NOT** have dental insurance.
_____ (initials): I/We **DO** have dental insurance (if so please continue below)
If you have dental insurance we will file the claims for you, as a complimentary service. We do ask that the correct insurance information be provided at the time of your appointment in order for us to timely file the claim and collect payments. If this information changes, it is the patients responsibility to update the office at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to Dr. Beverly Deacon.

Our office will provide you with an ESTIMATE of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates. It is possible that we could pre-authorize any treatment to verify plan coverage howerver this is not a guarantee that your insurance company will reimburse us/you according to these estimates.

Please Note that any difference in payment from your insurance company and your account balance is your responsibility. We emphasize that as dental care providers our relationship is with you, NOT your insurance company. If difficulty arises with payment from the insurance company, we will ask that you contact you carrier to rectify the problem. All expected insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient and/ or account holder
Estimated payment for services (copay)is due at the time services are provided.

I / We understand the above paragraph regarding dental insurance, and have had the oppurtunity to have any questions answered to the best of our office's ability.

_____ _____
Date Signature

Cancellations and Broken Appointments:

Your scheduled time has been saved only for YOU and the doctor and/ or hygienist.
In an effort to keep dental costs down while maintaining a high level of professional care, we respectfully request a 48 hour cancellation notice. Our message system will accept your cancellation calls for you and will record time/date of your calls to avoid a $55 charge on your account per hour missed. We appreciate your efforts to keep scheduled appointments and we will make every effort to continue to have convenient hours and pre-scheduling availability for you.

I / We understand the above paragraph regarding cancellation, and have had the oppurtunity to have any questions answered to the best of the office's ability.

_____ _____

Date Signature