STUART D. BEAUCHAMP, D.M.D

ORMOND BEACH PERIODONTICS & IMPLANT DENTISTRY

Patient Registration Form

NAME: _____ BIRTH DATE: _____ SOC. SEC. #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP:_____

PHONE #: (_____)_____ EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE #: (_____)_____

EMPLOYED BY: _____ PHONE #: (_____)_____

DO YOU HAVE DENTAL INSURANCE? YES / NO INSURANCE CARRIER: _____

SUBSCRIBER MEMBER ID #: _____ INSURANCE GROUP #: _____

PREFERRED PHARMACY: _____ADDRESS: _____

WHOM MAY WE THANK FOR REFERRING YOU: _____

PURPOSE OF VISIT: _____

MEDICAL INFORMATION

1. HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST FIVE YEARS? YES OR NO
   IF YES, FOR WHAT REASON? _____

2. HAVE YOU HAD RADIATION OR CHEMOTHERAPY? YES OR NO
   IF YES, FOR WHAT REASON? _____

3. ARE YOU CURRENTLY TAKING ANY DRUGS OR MEDICATIONS? YES OR NO
   IF YES, PLEASE LIST YOUR MEDICATIONS _____

4. ARE YOU ALLERGIC TO ANY MEDICATIONS? YES OR NO
   IF YES, LIST ALL _____

5. FOR WOMEN, DO YOU SUSPECT THAT YOU ARE PREGNANT? YES OR NO

6. TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

ALLERGIES	YES OR NO	DIABETES	YES OR NO
FAINTING SPELLS	YES OR NO	GLAUCOMA	YES OR NO
EAR PROBLEMS	YES OR NO	EPILEPSY	YES OR NO
TOBACCO USE	YES OR NO	HEPATITIS	YES OR NO
HIGH BLOOD PRESSURE	YES OR NO	HIV	YES OR NO
HEART PROBLEMS	YES OR NO	HEALING PROBLEMS	YES OR NO
MENTAL DISORDER	YES OR NO	NERVOUS DISORDER	YES OR NO
LUNG, BREATHING PROBLEMS	YES OR NO	CANCER	YES OR NO

BELOW ARE SOME QUESTIONS THAT RELATE TO YOUR DENTAL HISTORY. IF YOU HAVE TROUBLE WITH THESE QUESTIONS, PLEASE ASK US AND WE WILL BE GLAD TO ASSIST YOU.

1. ARE YOU EXPERIENCING ANY DENTAL DISCOMFORT AT THIS TIME? YES OR NO
   IF YES, WHERE AND FOR HOW LONG? _____
2. WHEN DID YOU LAST HAVE DENTAL X-RAYS TAKEN? _____
3. DO YOU GRIND YOUR TEETH? YES OR NO IF YES, DAY OR NIGHT
4. HOW FREQUENTLY DO YOU BRUSH YOUR TEETH? _____ FLOSS? _____
5. DO YOUR GUMS BLEED, ARE THEY SWOLLEN OR IRRITATED? YES OR NO
6. HAS A DENTAL VISIT EVER BEEN ESPECIALLY UNPLEASANT? YES OR NO
7. HAVE YOU EVER HAD YOUR GUMS TREATED? YES OR NO
8. ARE YOU HAPPY WITH YOUR SMILE? YES OR NO IF NO, PLEASE EXPLAIN: _____

I UNDERSTAND THIS IS MY MEDICAL CONDITION AS OF THIS DATE. IF THERE ARE ANY CHANGES IN MY MEDICAL CONDITIONS, I WILL CONTACT DR. BEAUCHAMP'S OFFICE.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY INSURANCE CLAIM THAT MY DOCTOR'S OFFICE MAY SUBMIT FOR ME.

I HEREBY AUTHORIZE DR. STUART BEAUCHAMP, OR ANY STAFF MEMBER OF DR. STUART BEAUCHAMP'S TO DISCUSS MY HEALTHCARE AND FINANCIAL/BILLING ISSUES WITH THE FOLLOWING PERSONS:

NAME: _____RELATIONSHIP: _____

NAME: _____RELATIONSHIP: _____

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION WHICH WILL REMAIN IN EFFECT UNTIL DR. BEAUCHAMP'S OFFICE IS NOTIFIED OF ANY CHANGES. _____ (INITIALS)

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____HAVE REVIEWED/RECEIVED A COPY OF NOTICE OF PRIVACY PRACTICE POLICY FROM DR. STUART BEAUCHAMP'S OFFICE.

SIGNATURE: _____ DATE: _____

WE ARE HAPPY TO ASSIST YOU IN FILING YOUR DENTAL INSURANCE. YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURSANCE COMPANY. WE DO OUR BEST TO ESTIMATE WHAT YOUR INSURANCE WILL PAY FOR YOUR TREATMENT. YOUR INSURANCE COMPANY WILL DETERMINE THEIR FINAL PAYMENT, ANY REMAINING BALANCE WILL BE YOUR RESPONSIBILITY.

SIGNATURE: _____DATE: _____

THANK YOU FOR YOU COOPERATION IN COMPLETING THIS FORM