TOMOKA PERIODONTICS
& IMPLANT DENTISTRY

Ormond Beach Office
35 Forest Ct
Ormond Beach, FL 32174
386-672-9440

Daytona Beach Office
815 North Nova Rd
Daytona Beach, FL 32117
386-252-8508

Palm Coast Office
7 Boulder Rock Dr, Suite 2
Palm Coast, FL 32137
386-446-8444

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Welcome to Our Practice

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to contact us.

Date _____

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name _____ Birth Date _____

Sex ☐ M ☐ F Address _____ City _____ State _____ Zip _____

☐ Minor ☐ Married ☐ Widowed ☐ Single ☐ Partnered ☐ Divorced

Home Phone _____ Cell Phone _____ Email _____

Spouse's Name _____ Spouse Phone _____

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____ City _____ State _____ Zip _____

Dentist _____ Medical Doctor _____

Whom may we thank for referring you? *(e.g., General Dentist)* _____

Contact in case of emergency _____ Phone _____ Relation to Patient _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other

(If self, skip to next section)

Name _____ S.S.# _____ Birth Date _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

Currently a patient in our office? ☐ Yes ☐ No Email _____ Cell Phone _____

PRIMARY DENTAL INSURANCE COMPANY

Subscriber _____ Relationship to Patient _____

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ City _____ State _____ Zip _____

Group# _____ ID# _____

Sex: ☐ M ☐ F Birth Date _____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell Phone _____ Email _____

MEDICAL HISTORY

Are you a nervous or tense person? ☐ Yes ☐ No Are you under the care of a physician? ☐ Yes ☐ No

Rate your dental fear: ☐ Mild ☐ Moderate ☐ Severe Last Physical Exam: Date _____

Have you had any illness, operation, or been hospitalized in the past five years? ☐ Yes ☐ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Yes No

- ☐ ☐ Abnormal Bleeding
- ☐ ☐ AIDS/HIV *(Circle One)*
- ☐ ☐ Anemia
- ☐ ☐ Arteriosclerosis
- ☐ ☐ Arthritis / Joint Disease *(Circle One)*
- ☐ ☐ Asthma
- ☐ ☐ Chemotherapy
- ☐ ☐ Cold Sores / Fever Blisters
- ☐ ☐ Contagious Diseases_____
- ☐ ☐ Convulsions / Epilepsy *(Circle One)*
- ☐ ☐ Delay in Healing
- ☐ ☐ Diabetes
- ☐ ☐ Eye Disease / Glaucoma *(Circle One)*
- ☐ ☐ Fainting Spells
- ☐ ☐ Frequent Headaches
- ☐ ☐ Hay Fever/Sinus Problems *(Circle One)*
- ☐ ☐ Heart Attack(s)
- ☐ ☐ Heart Condition
- ☐ ☐ Heart Murmur
- ☐ ☐ Hepatitis A B C *(Circle One)*
- ☐ ☐ High / Low Blood Pressure *(Circle One)*
- ☐ ☐ History of Drug Abuse

Yes No

- ☐ ☐ Immune Suppressive Disease
- ☐ ☐ Joint Replacement *(Specify Year & Joint)* _____
- ☐ ☐ Kidney Trouble
- ☐ ☐ Liver Disease / Jaundice *(Circle One)*
- ☐ ☐ Low Blood Sugar
- ☐ ☐ Mental Health Problems
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Osteoporosis / Osteopenia *(Circle One)*
- ☐ ☐ Pain in Jaw Joints
- ☐ ☐ Prostate Trouble *(Men)*
- ☐ ☐ Radiation
- ☐ ☐ Sexually Transmitted Diseases
- ☐ ☐ Smoke or Tobacco in Any Form
- ☐ ☐ Stomach Ulcers
- ☐ ☐ Stroke
- ☐ ☐ Tendency to Faint
- ☐ ☐ Thirsty / Dry Mouth
- ☐ ☐ Thyroid Problems
- ☐ ☐ Tuberculosis
- ☐ ☐ Tumor or Growth

For Women Only:

Is there a possibility of pregnancy? ☐ Yes ☐ No

MEDICATION AND ALLERGIES

Are you allergic to or had a reaction to:

Yes No

- ☐ ☐ Antibiotics *(specify)* _____
- ☐ ☐ Amoxicillin
- ☐ ☐ Aspirin
- ☐ ☐ Codeine or Other Narcotics
- ☐ ☐ Food *(specify)* _____
- ☐ ☐ Latex
- ☐ ☐ Local Anesthetic
- ☐ ☐ Penicillin
- ☐ ☐ Sulfa Drug

Other: _____

Have you been advised to pre-medicate for medical reasons *(e.g., antibiotics)* prior to dental treatment? ☐ Yes ☐ No

List all medication(s) you are currently taking (including natural, herbal, or homeopathic products):

_____

_____

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* _____ **Reviewed by:** _____ **Date:** _____

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 my Periodontist, or any staff member of Dr. Stuart Beauchamp's, to discuss my healthcare and financial/billing issues with the following person:

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 insurance company. Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to contact us.

Thank you for your cooperation in completing this form.