Beckman Dental
EXCELLENCE

WELCOME!
Thank you for selecting us!

Date_____

Patient Information

Name_____ I prefer to be called_____
Address, City, State, Zip_____
Home Phone_____ Work Phone_____Cell Phone_____
E-Mail_____
Social Security #_____ Birthday_____
Drivers License # of responsible party _____

Single Married Separated Divorced Widowed

Whom may we thank for referring you to us?_____
Person to contact in case of emergency:
Name_____ Phone _____

Responsible Party
Person Responsible for this Account_____Relationship_____
Address, City/St, Zip _____
Home Phone_____ Work Phone_____ Cell Phone_____

Dental Insurance Information

Primary Dental Coverage:
Insurance Company_____Insurance Phone #_____
Address_____ Group #_____
Subscriber Name_____ Date of Birth_____
Member ID #_____ SS#_____
Employer_____

For your convenience, we offer the following methods for payment. Please check the option you prefer. Cash Check Credit Card CareCredit

Secondary Dental Coverage:
Insurance Company_____ Address_____
Subscriber Name_____ Date of Birth_____
Member ID_____ SS#_____ Group#_____
Employer_____

Patient Medical History

Physician_____
Office Phone_____ Last Exam_____
Are you under medical treatment now? Yes No Explain _____
Have you been hospitalized or had a serious illness in the last three years? Yes No
Explain_____
List any medications you are taking now (including aspirin)_____
Are you allergic to or have you had any reactions to any of the following?

Penicillin	Yes	No	Local Anesthetics	Yes	No
Other Antibiotic	Yes	No	Codeine	Yes	No
Other Medications	Yes	No			

Please list
_____

Women Only: Are you pregnant? Yes No Unsure Nursing? Yes No
Taking Birth Control Pills? Yes No

Women taking birth control medications should be aware that antibiotics can cause the birth control medications to be ineffective possibly resulting in pregnancy.

Do you have, or have you had, any of the following?

Abnormal Blood Pressure	Yes	No	Glaucoma	Yes	No
Heart Disease	Yes	No	Anemia	Yes	No
Heart Murmur	Yes	No	Arthritis	Yes	No
Mitral Valve Prolapse	Yes	No	Thyroid Problems	Yes	No
Rheumatic Fever	Yes	No	Kidney Disease	Yes	No
Tuberculosis/Lungs	Yes	No	Cancer	Yes	No
Epilepsy/Convulsions	Yes	No	Leukemia	Yes	No
Fainting/Seizures	Yes	No	Radiation Therapy	Yes	No
Joint Replacement	Yes	No	Liver Disease	Yes	No
Asthma/Respiratory	Yes	No	Hepatitis/Jaundice	Yes	No
Hay Fever/ Allergies	Yes	No	Stroke	Yes	No
Prolonged Bleeding	Yes	No	Diabetes	Yes	No
HIV+/AIDS	Yes	No	Stomach Problems	Yes	No

Other conditions not listed
_____
Do you smoke cigarettes or use tobacco? Yes No
Updates_____
_____
_____

Authorization and Release: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information may be dangerous to my health. I authorize the dentist to release any information, including diagnosis and the records of any treatment or examination rendered to me, my spouse, or my child during the period of such dental care to third party payers or health practitioners or my spouse.

_____ *Messages may be left at my home, work or cell numbers regarding appointments, pre-medication or treatment.*
(Please initial)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
**** You may refuse to sign this acknowledgement****

I have received a copy of this "Notice of Privacy Practices" and agree to disclosures of my health information as stated above.

Signature:_____ Date_____

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Dental History

This form is used so that we can personalize your dental care and cater to your needs. This information is usually very helpful.

1. What can we do to help you?

_____

_____

_____

2. How long has it been since your last dental appointment? _____

3. Have you had problems with prior dental treatment? Yes No

4. Are you in pain now? Yes No

5. Do you have pain, clicking, or popping in your jaw joint (TMJ)? Yes No

6. How nervous are you about coming to the dentist? (Please Circle One)

Very Nervous / A Little Nervous / Not Nervous at All

7. How much would you like to learn about dentistry? In other words, how much would you like Dr. Beckman to tell you about what he is doing? (Please Circle One)

Every Little Detail / A Little Bit / Nothing at All

8. Are you happy with the way your smile looks? Yes No

If not, what would you change?

_____

_____

_____

9. Would you be interested in whitening (bleaching) your teeth? Yes No

10. Would you like to learn more about how you can improve your smile? Yes No

11. How did you hear about us? _____

Name: _____

Signature: _____ Date: _____

Kenneth B. Beckman, D.M.D.
Financial Arrangements and Office Policies

For all patients:
Payment for services is expected at the time services are provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. Cash, Checks, Visa, MasterCard, American Express, Discover and Care Credit are all accepted for your convenience. If an extended payment plan is desired, please ask us about our third party payment plan.

For patients with dental insurance:
We accept most dental insurance and will maximize your coverage to the fullest extent possible. As a complementary service, we will file your insurance claims with your insurance company. We will estimate your deductible and the portion not covered by your insurance. Our estimates may differ somewhat from your insurance company's calculations; and the amount due to our office will be adjusted accordingly. All procedures that are not covered by insurance are ultimately the patient's responsibility.

The undersigned agrees to pay any and all expenses, which the doctor may incur in collecting delinquent balances including; court costs, credit agency costs, and any and all attorneys frees (approximately 35% of unpaid balances.) Our accounts are sent to Executive Credit Bureau for collections.*

Please note, all accounts will be subject to a 7% finance charge on all unpaid balances over 60 days.*

Office Policy:
If the need to cancel a scheduled appointment arises, we require 24 hours notification. Appointments canceled within 24 hours or "No Show" appointments may be subject to a fee.

Our Promise to you:

Our team will provide excellent dental care in a professional, yet personalized, environment. We are committed to a level of quality that will exceed your expectations.

Kenneth B. Beckman, D.M.D. and Staff

Print Name	Signature	Date

on all completed dental treatment