Beadnell Family Dentistry

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date: _____ E-mail Address: _____

Name: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr
I prefer to be called: _____ ❑ Non-Binary

Birthdate: ___/___/___ Age: _____ ❑ Single ❑ Married ❑ Partner

Home Address: _____
Street City State Zip

Home Phone #: (_____)_____ Cell: (_____)_____ Work Phone #: (_____)_____ Ext: ____

Where & when are best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (_____)_____ Home Phone #: (_____)_____

Address: _____
Street City State Zip

Spouse Information

His / Her Name: _____ Birthdate: ___/___/___

Employer: _____ Work Phone #: (_____)_____ Ext: _____

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ ID #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (_____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ ID #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

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503-244-4837 (Office) | 503-293-3480 (Fax) | 1616 SW Sunset Boulevard | Suite A | Portland, OR 97239 | www.beadnellfamilydentistry.com

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease or treatment? ❑ Yes ❑ No

Do you grind your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Would you like whiter teeth? ❑ Yes ❑ No

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

If not, what would you change? _____

_____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
Street

_____
City State Zip

Phone #: (____)_____ Date of last visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you ever taken Bisphosphonates (Fosamax, ect)? ❑ Yes ❑ No

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Chronic Headaches	Y N Fever Blisters	Y N Kidney Problems	Y N Shingles
Y N Alcohol Abuse	Y N Colitis	Y N Glaucoma	Y N Liver Disease	Y N Sickle Cell Disease
Y N Anemia	Y N Congenital Heart Defect	Y N Hay Fever	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Diabetes	Y N Heart Attack	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Difficulty Breathing	Y N Heart Murmur	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Drug Abuse	Y N Heart Surgery	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Emphysema	Y N Hemophilia	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Epilepsy	Y N Hepatitis	Y N Radiation Treatment	Y N Ulcers
Y N Cancer	Y N Erectile Dysfunction	Y N Herpes	Y N Seizures	Y N Venereal Disease
Y N Chemotherapy	Y N Fainting Spells	Y N High/Low Blood Pressure		
Y N Chicken Pox		Y N HIV+/AIDS		

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No If yes, please list each one and reason why:

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions: _____

_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I understand that any schedule changes with less than 48 hours notice may result in charges for time reserved.

_____
Signature Date

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