Beachwood Smiles **Yoav Y. Taub DDS, Inc.**

PATIENT INFORMATION

DATE _____

NAME _____ ❑Married ❑Single ❑Minor ❑Male ❑Female
LAST FIRST M/I

ADDRESS _____ DATE OF BIRTH ___/___/___
STREET APT. # CITY STATE ZIP MONTH DAY YEAR

PHONE HOME: ( )_____ ___ CELL : ( )_____ _____ E-MAIL _____
HOME # WORK #

PLACE OF EMPLOYMENT _____ SOCIAL SECURITY #_____-_____-_____

IF FULL TIME STUDENT, NAME OF SCHOOL _____GRADE LEVEL _____

Has any member of your family been treated in our practice? ❑YES ❑NO NAME _____

Whom may we thank for referring you to our dental practice? _____

Emergency Contact: _____Phone: _____

ACKNOWLEDGMENT AND AUTHORITY

- The information on this page and the dental/medical histories are correct to the best of my knowledge.
- I hereby authorize the Dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.
- I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me.
- I grant the right to the dentist to release my dental/ medical and other information about my dental treatment to third party payors and/or other health professionals, as appropriate under the circumstances.
- I also acknowledge full responsibility for the payment of fees for such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangements are made in writing with a practice representative.
- I have received a copy of the HIPAA Privacy Policy as required by law.
- I grant the dental office permission to use the email address given above to contact me with respect to my dental care.

X_____
❑Adult Patient ❑Father or Husband ❑Mother or Wife ❑Guardian

PERSON RESPONSIBLE FOR ACCOUNT

Please check one

❑Patient ❑Husband (or Father)

❑Guardian ❑Wife (or Mother)

Responsible party has an account with this office:

❑Yes ❑No

METHOD OF PAYMENT (unless otherwise arranged)

❑ I will pay in full at each appointment (cash or check)

❑ I will pay in full at each appointment ❑V ❑MC❑D❑AE

❑ I have a dental benefit plan that I expect will pay for most routine charges. I will pay my deductible and any patient portion at time of service.

ORAL HEALTH INFORMATION

1. Any known dental problems at this time? ❑Yes ❑No Describe _____
2. Are any of your teeth sensitive to hot, cold, biting pressure, or sweets? ❑Yes ❑No Describe _____
3. Do your gums bleed when your brush or floss? ❑Yes ❑No Describe _____
4. Have you ever been told you have periodontal (gum) disease? ❑Yes ❑No Describe _____
5. Are there areas in your mouth you avoid chewing on? ❑Yes ❑No Describe _____
6. Do your jaw joints (TMJ) click, pop, or cause pain? ❑Yes ❑No Describe _____
7. Are you aware of any nighttime clenching or grinding of your teeth? ❑Yes ❑No Describe _____
8. Do your teeth show signs of chipping and wear? ❑Yes ❑No Describe _____
9. Do you have areas of gum recession? ❑Yes ❑No Describe _____
10. If there anything you would like to change about your smile? _____

PATIENT HEALTH INFORMATION

DATE _____

NAME _____
LAST FIRST M/I

MEDICAL HEALTH INFORMATION

1. Physician's Name _____ Date last seen_____
2. Are you under a physician's care now? ❑Yes ❑No Discuss reason_____
3. Have you had any serious illnesses or operations? ❑Yes ❑No
4. Are you taking any medications, pills or drugs? ❑Yes ❑No Please List _____
5. **Are you allergic to any medication or substances? ❑Aspirin ❑Penicillin ❑Codeine ❑Novocain ❑Other**_____
6. **WOMEN (Please check if applicable) ❑Pregnant (Due date _____) ❑Nursing ❑ Birth Control**
7. Do you have, or have you ever had, any of the following? (please check and describe below):

Yes	No		Yes	No		Yes	No	
❑	❑	Prosthetic Joints	❑	❑	Excessive bleeding	❑	❑	Fainting or dizziness
❑	❑	Heart Disease	❑	❑	Hepatitis/Liver Disease	❑	❑	Stroke
❑	❑	Latex Allergy	❑	❑	AIDS/HIV	❑	❑	Diabetes
❑	❑	High blood pressure	❑	❑	Tuberculosis	❑	❑	Psychiatric treatment
❑	❑	Cancer	❑	❑	Other transmittable disease	❑	❑	Epilepsy or seizures
❑	❑	Frequent Headaches	❑	❑	Osteoporosis	❑	❑	Glaucoma
			❑	❑	Breathing Problems			

9. Do you know of any reason why routine dental procedures might pose a risk to you, the dental staff, or other patients? ❑Yes ❑No
10. Is there anything important about your medical condition we have not asked? _____

Remarks _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

X_____ Date _____
Patient's Signature (Parent or Guardian)