DREW BEATY DDS
family and cosmetic dentistry

Medical Alert For Office Use

Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

_____
CITY STATE ZIP

Employer _____ Position _____ How Long? _____

Birth date _____ ❑ Male ❑ Female

Phone: Home _____ Social Security # _____

Work _____ May we contact you at work? ❑ Yes ❑ No

Mobile _____

Emergency: Name _____ Phone _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the office of Dr. Robert Beaty of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dr. Beaty's office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ **Date** _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

_____
CITY STATE ZIP TELEPHONE

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Other Information

How did you hear about us?

_____

What was the reason for today's visit?

_____

Is there anything about your smile that you would like to change?

_____

Why did you leave your last dentist?

_____

What did you like *most* about your last dentist?

_____

Are you apprehensive about dental treatment? _____

Are your teeth sensitive? _____

Does food catch between your teeth? _____

Do you experience headaches more than once a week? _____

Do you expect to keep your teeth your whole life? _____

Would you like to receive correspondence via email? _____Email Address:_____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated.

- Payment for all treatment and services rendered are my responsibility.
- A notice of 2 business days to cancel an appointment is required, or a fee may apply.

_____ _____

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

_____ _____

PARENT/GUARDIAN SIGNATURE DATE