FAIRCHANCE
DENTAL ARTS

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number		Drivers Licence Number	Date of Birth
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip

PERSON RESPONSIBLE FOR ACCOUNT ☐ Check here if same as above

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number		Drivers Licence Number	Date of Birth
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip

Turn Page Over

INSURANCE INFORMATION

☐ Check here if you do not have Dental Insurance ☐ Check here if you previously provided information

Insured's First & Last Name		Date of Birth	Social Security
Name of Insured's Employer			Patient Relationship to Insured
Insurance Company	Phone	Subscriber ID#	Group ID#
Insurance Company Address	City	State	Zip

*A 3.95% processing fee is added to any credit card transaction.

REFERRAL INFORMATION

How did you first hear about our office? ☐ Another patient (relative) ☐ Another patient (friend) ☐ New patient flyer ☐ Yahoo
☐ Another dental or medical office ☐ School ☐ Work ☐ Church ☐ Drive by office ☐ Google ☐ Yelp ☐ Yellow pages
☐ Employee ☐ Community/charity event ☐ Insurance company ☐ Health/benefits fair or event

If you were referred to us by someone, please write their name _____

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CHILD HEALTH/DENTAL HISTORY FORM

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (CITY / STATE / ZIP CODE)		
Phone (Home / Work)	Sex M ☐ F ☐	

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV/AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex allergy	☐ Rheumatic fever	☐ General Disease
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other_____
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Sickle cell	

Please list the name and phone number off the child's physician:

Name of Physician_____Phone_____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over-the-counter medications or vitamin supplements at this time? If yes, please list:_____	☐	☐
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain:_____	☐	☐
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	☐	☐
4.	Has the child ever had a serious illness? If yes, when: _____ Please describe:_____	☐	☐
5.	Has the child ever been hospitalized?	☐	☐
6.	Has that child ever received a general anesthetic?	☐	☐
7.	Has the child ever had a blood transfusion?	☐	☐
8.	Is the child physically, mentally, or emotionally impaired?	☐	☐
9.	Does the child experience excessive bleeding when cut?	☐	☐
10.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dental visit? Date:_____	☐	☐
11.	Has the child had any problem with dental treatment in the past?	☐	☐
12.	Has the child ever suffered any injuries to the mouth, head, or teeth?	☐	☐
13.	Has the child had any orthodontic treatment?	☐	☐
14.	What type of water does your child drink?	☐	☐
15.	Is fluoride toothpaste used?	☐	☐
16.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed?_____		
17.	Does the child participate in active recreational activities?	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____
Parent's/Guardian's Signature Date

Caleb S. Beam, D.D.S. | Megan K. Beam, D.D.S.
5 N Morgantown St., Fairchance, PA, 15436 | 724-564-9010 | FairchanceDentalArts.com

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CONSENT FOR TREATMENT

I authorize the doctor and designated team members to gather the information necessary to make a thorough diagnosis of my dental needs. In general, diagnostics include radiographs, study models, periodontal measurements, photographs and/or other aids deemed appropriate by the doctor to make an accurate diagnosis. Radiographs are required to complete your examination, diagnosis, and treatment plan.

I understand there are risks involved in receiving dental treatment, as well as risks involved in choosing not to obtain the treatment recommended. I understand that I can ask for a complete recital of any possible complications.

The treatment specifically recommended for you will be explained to you in detail. It can include, but is not limited to, the following:

- Dental Cleanings (above the gum line)
- Periodontal Treatment (below the gum line)
- Fillings
- Crowns, Bridges, Veneers
- Implants
- Tooth Extractions
- Orthodontics
- Root Canal Therapy
- Temporomandibular Joint Dysfunction
- Sleep Apnea

I understand during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I give my permission to make any changes and additions as necessary.

I understand that I have the right to choose on the basis of adequate information, from alternative treatment plans that meet the doctor's professional standard of care. It is important to provide your dentist with an accurate medical history before, during, and after treatment. It is equally important to follow your dentist's advice and recommendations regarding medication, pre- and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled follow-up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I have read each paragraph above and consent to recommended treatment as needed.

_____
Patient Name

_____ _____
Patient/Guardian Signature Date

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