Patient Registration & Medical History

Robert J. Bey, D.D.S.

Date__________________ Home Phone_____________________________________

Patient's Name____ Email____

Preferred Name____ Cell Phone #_____________________________________

Address____ City___________________________Zip____________

Sex: ❑M ❑F Age________Birth date______________________ Marital Status_____________________________________

Social Security #____

Employer____ Business Phone __________________________________

Business Address____ Occupation _____________________________________

Name of Spouse/Parent______________________________________ Spouse's Employer_______________________________

Spouse Employer Address____________________________________ Spouse Business Phone___________________________

Who referred you to our office?_______________________________

INSURANCE INFORMATION

Dental Insurance Co.____

Group Number_________________Insured's Date of Birth____________________

Insured's S.S. #____

FAMILY MEMBERS IN OUR CARE

____

____

_____ ____

MEDICAL HISTORY

Physicians Name____Phone Number_________________________

Are you taking any medications at this time?(please list)____

____

Have you ever had? (please circle)

High/Low Blood Pressure	Diabetes	Sinus Trouble
Heart Attack	Epilepsy	Asthma or Hay fever
Heart Surgery	Tuberculosis/Lung Disease	Artificial Knee/Hip
Heart Murmur/ Mitral Valve Prolapse	Glaucoma	Kidney Disease
Rheumatic Fever/ Heart Disease	Ulcer	Thyroid Disease
Congenital Heart Problems	Cancer	Liver Disease
Artificial Heart Valve/Pacemaker	Arthritis	Hepatitis
Stroke	Fibromyolgia	Osteoporosis
Congestive Heart Disease	HIV Infection (AIDS)	Drug/Alcohol Dependency
Anemia	Headaches	Acid Reflux

Are you allergic to: ❑Penicillin ❑Latex ❑Codeine ❑Anesthetics ❑Other Medications_________________

Do you smoke or use tobacco products in any form?____

Have you ever responded adversely to medical or dental treatment?_______________________________________

Are you subject to prolonged bleeding? Yes ❒ No ❒

Is there anything else we should know about you medical history?____

Women: Are you taking birth control pills?........Yes No

Are you pregnant?...............................Yes No How many weeks?_________________________

Are you nursing?................................Yes No

Are you happy with your smile?________________If not, why?____

Do you ever have jaw joint (TMJ) pain?____

Signature____ Please read other side ⟹

Financial Policy

We appreciate payment when services are rendered!

Your account is to be paid in full within 30 days of receipt of your statement unless other arrangements have been made with our office.

Charges not paid within 45 days of receipt of your statement are subject to a finance charge of 1.50% per month (18% annual rate).

To our patients with insurance

As a courtesy to you, we will complete and file insurance forms for your dental treatment. *You are responsible for verifying benefits and coverage percentages.* When benefits are assigned to us, we do not require you to pay the balance in full; we ask only that you pay the *estimated* amount the insurance company will not cover. Balances outstanding 30 days after payment by the insurance company will be subject to a finance charge unless prior arrangements have been made. The ultimate responsibility for this account remains yours. In the event of an extended insurance delay or disputed claim, we may require your immediate payment of the balance.

I have read and understand the above financial policy.

____ __________________

Signature Date

Robert J. Bey, DDS
4690 Genesee Avenue
San Diego, California 92117
(858 279-2226