Ian M. Bever, D.D.S.
Bever Family Dentistry

Patient Information

Name_____ Date:_____
First MI Last
Address_____City_____State___Zip_____
Email_____Cell Phone (989)_____Home Phone (989)_____
SS#_____ Birthdate_____
Martial Status: (circle one) Single Married Divorce Widowed Seperated
If College Student FT / PT Name of School_____City_____State_____
Patient Employer_____Work Phone (___)_____
Employer Address_____City_____State_____Zip_____
Spouse or Parent Name_____Employer_____Work Phone(___)_____
Whom may we thank for referring you?_____Emergency Contact_____

Emergency Information

Name of nearest relative not living with you_____Relation_____
Complete Address_____Phone #_____

Responsible Party Information

Name_____Marital Status_____
First MI Last
Residence Address_____
How long at this address?_____Birthdate__/___/____SS#_____
Drivers License_____Relationship to Patient_____
Home Phone (___)_____Cell (___)_____
Employer Address_____Work Phone (___)_____

Responsible Party Spouse

Name_____SS#_____
Cell Phone (___)_____Birthdate__/___/_____Employer_____
Employer Address_____# Years Employed_____Employer Phone (___)_____

Primary Dental Insurance

Insured's Name_____Insured's SSN_____Birthdate__/___/_____
Ins Company_____ ID#_____Group#_____
Address to mail claim to:_____

Secondary Dental Insurance

Insurance Phone (___)_____Insured's Employer_____
Insured's Name_____Insured's SSN_____Birthdate__/___/_____
Ins Company_____ ID#_____Group#_____
Address to mail claim to:_____
Insurance Phone (___)_____Insured's Employer_____

Bever Family Dentistry Medical History Form

Patient Name: Birth Date: Today's Date:

Although we primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, medication that you may be taking, could have an important interrelationship with the dentistry you receive.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever: been hospitalized or had a major operation?	○ Yes ○ No	If yes
Had a serious head or neck injury?	○ Yes ○ No	If yes
Taking any medications, pill, or drugs?	○ Yes ○ No	If yes
Taking or ever taken Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use a controlled substance?	○ Yes ○ No	If yes

Women: Are you… ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Are you allergic to any of the following?

☐Aspirin	☐Penicillin	☐Codeine	☐Acrylic	☐Other _____
☐Metal	☐Latex	☐Sulfa Drugs	☐Local Anesthetics	_____

Do you have, or have you had any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent WEIGHT Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatis	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizzy	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble Spina Bifida	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Stomach/Intestinal disease	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stroke	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoperosis	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Ulcers	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian _____ Date:_____

Phone (989)892-7663 Fax (989)892-8850 thebaycitydentist.com 512 S. Trumbull Street, Bay City