Beaver Dental Care

Zan Beaver, DMD
Lily Gilchrist, DDS

WELCOME TO OUR PRACTICE

On behalf of the entire team at Beaver Dental Care, let us welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequaled advanced training in cosmetic and reconstructive dentistry we have received.

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed Personal Information Sheet and Medical and Dental History questionnaire that should be filled out prior to your first appointment with us.

Be sure to visit our website at www.BeaverDental.com. We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

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Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form. All of this information is completely confidential.

PATIENT INFORMATION

M F S M D W

Name (Last) (First) (Middle) Date of Birth Sex Marital Status Social Security Number

Preferred Name Email Address Cell Phone Number

Home Address (Street) (City) (State) (ZIP Code) Home Phone Number

Name of Employer Occupation

Business Address (Street) (City) (State) (ZIP Code) Business Phone Number

Emergency Contact Phone Number

Spouse's Name

Spouse's Employer Occupation

How did you hear about our office? ______________________________

RESPONSIBLE PARTY INFORMATION

Who is responsible for account? ❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other

Please fill in the following information if the person responsible is different from self.

Relation to patient: ______________________________

Name (Last) (First) (Middle) Date of Birth Social Security Number

Home Address (Street) (City) (State) (ZIP Code) Home Phone Number

Name of Employer Occupation Business Phone Number

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DENTAL INSURANCE INFORMATION

Is patient covered by dental insurance? ❑ Yes ❑ No

If yes, please complete the following:

___

Policy Holder Name (Last) (First) (Middle) Date of Birth Social Security Number

___

Name of Employer Occupation Business Phone Number

___

Business Address (Street) (City) (State) (ZIP Code) Dental Insurance Co.

Group # ______________________ Subscriber ID # ______________________

Is patient covered by additional dental insurance? ❑ Yes ❑ No

If yes, please complete the following:

___

Policy Holder Name (Last) (First) (Middle) Date of Birth Social Security Number

___

Name of Employer Occupation Business Phone Number

___

Business Address (Street) (City) (State) (ZIP Code) Dental Insurance Co.

Group # ______________________ Subscriber ID # ______________________

INSURANCE AUTHORIZATION & FINANCIAL RESPONSIBILITY AGREEMENT

I understand that I am financially responsible for all charges whether or not paid by insurance. I assign all insurance benefits directly to the doctor otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

___

Signature (Parent/Guardian if under age 18) Relationship (if patient is under age 18) Date

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MEDICAL HISTORY

Patient Name: ___________________________________

Physician's Name: ________________________________ Phone: ____________________ Date of Last Visit: ___________________

Please check the box if you have ever had any of the following:

- ❏ AIDS or HIV positive
- ❏ Acid Reflux or G.E.R.D
- ❏ Arthritis (Supply Type in "Details" Below)
- ❏ Artificial joints
- ❏ Asthma
- ❏ Cancer
- ❏ Chemical dependency
- ❏ Diabetes (Supply Type in "Details" Below)
- ❏ Eating disorder
- ❏ Epilepsy
- ❏ Excessive bleeding
- ❏ Glaucoma
- ❏ Hepatitis (Supply Type in "Details" Below)
- ❏ Kidney problems
- ❏ Liver problems or jaundice
- ❏ Lung or breathing problems
- ❏ Sinus trouble
- ❏ Smoking or chewing tobacco
- ❏ Stroke
- ❏ Swollen neck glands
- ❏ Thyroid problems
- ❏ Tuberculosis

Give details and location of the above checked items: ____

____

Heart Problems

- ❏ Low blood pressure
- ❏ High blood pressure
- ❏ Pacemaker
- ❏ Artificial valves
- ❏ Infective (bacterial) endocarditis
- ❏ Congenital heart defects
- ❏ Heart surgeries
- ❏ Other ____

Allergies

- ❏ Aspirin
- ❏ Codeine
- ❏ Latex
- ❏ Local anesthetic
- ❏ Penicillin
- ❏ Sulfa
- ❏ Other ____

- ❏ Antibiotics for dental treatment
- ❏ Currently under a physician's care
- ❏ Serious illnesses/hospitalizations

Medications

Please list medications you are currently taking and why.

____

____

Women

Are you pregnant? ❏ Yes ❏ No If yes, expected delivery date: _______________

Are you nursing? ❏ Yes ❏ No Are you taking birth control pills? ❏ Yes ❏ No

1677 Art Museum Drive • Jacksonville, FL 32207 • (904) 201-3571
www.BeaverDental.com

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DENTAL HISTORY (NEW PATIENTS ONLY)

Please check the box if you have ever had any of the following:

❏ Bad breath problem
❏ Canker sores in mouth
❏ Orthodontics (braces)
❏ Oral surgery
❏ Frequent headaches, neck aches
❏ Cold sores on outer lips
❏ Full dentures or partial dentures
❏ Excessive gag reflex
❏ TMJ, jaw joint pain or treatment
❏ Dental anesthetic problems
❏ Biteguard or nightguard
❏ Fear of dental care
❏ Gum disease treatment

Please check the box if you currently have any of the following:

❏ Pain
❏ Toothache
❏ Vague ache
❏ Swelling
❏ Sensitivity to - heat - cold - biting
❏ Sensitivity to - sweets - pressure
❏ Broken tooth or filling
❏ Loose tooth
❏ Dry mouth
❏ Mouth breathing
❏ Sores or growths in mouth
❏ Bleeding gums
❏ Food packing between teeth
❏ Clicking or popping jaw
❏ Clenching or grinding of teeth
❏ Tired, sore or painful jaw joint
❏ Pain around ear

Other: ______________________________

Give details and location of the above checked items: ______________________________

____

How often do you brush? ______________ How often do you floss? ______________

What type toothbrush do you use? ❏ Ultrasoft ❏ Soft ❏ Medium ❏ Hard ❏ Electric

Reason for today's visit: ______________________________

Former Dentist: ______________ City/State: ______________ Phone: __________

Date and reason of last dental visit: ______________________________

Date of last dental X-rays: ______________

What have you liked about any dental office you've been to? ______________________________

What have you liked LEAST about any dental office you've been to? ______________________________

TREATMENT AUTHORIZATION

I have reviewed the information on this form and it is accurate to the best of my knowledge. I authorize and give consent for the dentist and/or team of this office to perform dental services as agreed between doctor and patient and/or guardian, including the use of local anesthetic and other medication as indicated.

____

Signature (Parent/Guardian if under age 18) Relationship (if patient is under age 18) Date