BENAGE
DENTAL CARE

WELCOME

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

PATIENT INFORMATION (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/ Prop. _____ Zip/ P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/ Prop. _____ ☐ Full TIme ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Address _____ City _____ State/ Prop. _____ Zip/ P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's Licence # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy

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INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State/ Prop. _____ Zip/ P.C. _____

Insurance Company _____ Group# _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/ Prop. _____ Zip/ P.C. _____

How much is your deductible? _____ How much have you used? _____

Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No **IF YES, COMPLETE THE FOLLOWING:**

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work Phone _____

Address of Employer _____ City _____ State/ Prop. _____ Zip/ P.C. _____

Insurance Company _____ Group# _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/ Prop. _____ Zip/ P.C. _____

How much is your deductible? _____ How much have you used? _____

Max. annual benefit _____

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PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

1. YES NO Are you under medical treatment now? _____
2. YES NO Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____
3. YES NO Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____
4. YES NO Have you ever taken Fen-Phen/Redux? _____
5. YES NO Have you ever taken Fosamax, Bonita, Actonel, or any cancer medications containing bisphosphonates? _____
6. YES NO Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours? _____
7. YES NO Do you use tobacco? _____
8. YES NO Do you use controlled substances? _____
9. Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies
☐	☐	Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy
☐	☐	Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble
☐	☐	Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other

10. YES NO Are you wearing contact lenses?
11. Are you allergic to or have you had any reactions to the following?
    - YES NO Local Anesthetics (e.g. Novocain)
    - YES NO Penicillin or any other Antibiotics
    - YES NO Sulfa Drugs
    - YES NO Barbiturates
    - YES NO Sedatives
    - YES NO Iodine
    - YES NO Aspirin
    - YES NO Any Metals (e.g. nickel, mercury, etc.)
    - YES NO Latex Rubber
    - Other (please list) _____
12. YES NO Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?
13. Women Only:
    - YES NO Are you pregnant or think you may be pregnant?
    - YES NO Are you nursing?
    - YES NO Are you taking oral contraceptives?

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PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. YES NO Do your gums bleed while brushing or flossing?
2. YES NO Are your teeth sensitive to hot or cold liquids/foods?
3. YES NO Are your teeth sensitive to sweet or sour liquids/foods?
4. YES NO Do you feel pain to any of your teeth?
5. YES NO Do you have any sores or lumps in or near your mouth?
6. YES NO Have you had any head, neck, or jaw injuries?
7. Have you ever experienced any of the following problems in your jaw?
   - YES NO Clicking
   - YES NO Pain (joint, ear, side of face)
   - YES NO Difficulty in opening or closing
   - YES NO Difficulty in chewing
8. YES NO Do you have frequent headaches?
9. YES NO Do you clench or grind your teeth?
10. YES NO Do you bite your lips or cheeks frequently?
11. YES NO Have you ever had any difficult extractions in the past?
12. YES NO Have you ever had any prolonged bleeding following extractions?
13. YES NO Have you had any orthodontic treatment?
14. YES NO Do you wear dentures or partials? If yes, date of placement _____
15. YES NO Have you ever received oral hygiene instructions regarding the care of your teeth and gums?
16. YES NO Do you like your smile?

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of sun dental care to third party mayors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Signature Date

Doctor's Comments _____

_____

_____

_____

_____

_____

_____ _____

Signature Signature Date

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