Welcome to Dental Ben's
New Patient Information

Date: _____

Patient Name:_____

Birthdate_____Age_____ Sex (M)___(F) ___SS # _____

Street Address_____

City_____ State_____ Zip Code _____

Parent/Guardian Address (If different)_____

Phone #_____ Cell # _____

Email _____

Did someone refer you?_____ _____

How did you hear about us? Flier _____Google_____ Social Media _____

EMERGENCY CONTACT

Name _____ Relationship _____

Phone #_____ Cell # _____

INSURANCE INFORMATION

Insurance Company _____ Phone #_____

ID#_____ Group # _____

Subscriber Name (if different from Patient) _____

Subscriber Birthdate_____ SS Number_____ Relationship_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above named Insurance Company and assign directly to Dental Ben's all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dental Ben's may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits payable for related services. This consent will stay in effect as long as I am a patient with Dental Ben's.

Signature_____ Parent/Guardian_____

Date _____ Relationship to Patient_____

HEALTH HISTORY

Patient Name: _____

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last 3 years? If yes, why?
   _____
4. Yes No Are you being treated by a Physician now? For what? _____
5. Date of last medical exam? _____ Physician's contact info:_____
6. Date of last dental exam? _____ _____
7. Yes No Have you had problems with prior dental treatment? Describe:_____
8. Yes No Are you in pain now?
9. Yes No Have you ever taken an antibiotic before dental treatment or been told you need to?

HAVE YOU EXPERIENCED:

1.	Yes	No	Chest pain (angina)?	12.	Yes	No	Dizziness?
2.	Yes	No	Swollen ankles?	13.	Yes	No	Ringing in ears?
3.	Yes	No	Shortness of breath?	14.	Yes	No	Headaches?
4.	Yes	No	Recent weight loss, fever, sweats?	15.	Yes	No	Fainting spells?
5.	Yes	No	Persistent cough, coughing blood?	16.	Yes	No	Blurred vision?
6.	Yes	No	Bleeding problems, bruise easily?	17	Yes	No	Seizures?
7.	Yes	No	Sinus problems?	18.	Yes	No	Excessive thirst?
8.	Yes	No	Difficulty swallowing?	19.	Yes	No	Frequent urine?
9.	Yes	No	Diarrhea, constipation, bloody stool?	20	Yes	No	Dry Mouth?
10.	Yes	No	Frequent vomiting, nausea?	21.	Yes	No	Jaundice?
11.	Yes	No	Difficulty urinating, blood in urine?	22.	Yes	No	Joint pain, stiff?

DO YOU OR HAVE YOU HAD:

1.	Yes	No	Heart Disease	17.	Yes	No	HIV?
2.	Yes	No	Heart Attack, Heart Defects?	18.	Yes	No	AIDS?
3.	Yes	No	Heart murmurs?	19.	Yes	No	Arthritis, rheumatism?
4.	Yes	No	Rheumatic fever?	20.	Yes	No	Eye diseases?
5.	Yes	No	Stroke, hardening of arteries	21.	Yes	No	Skin diseases?
6.	Yes	No	High Blood Pressure	22.	Yes	No	Anemia?
7.	Yes	No	Asthma, TB, Emphysema, other lung diseases?	23.	Yes	No	Venereal Disease?
8.	Yes	No	Hepatitis, other liver disease?	24.	Yes	No	Herpes?
9.	Yes	No	Stomach problems, ulcers?	25.	Yes	No	Kidney, bladder disease?
10.	Yes	No	Allergies to: Drugs, foods, Medication, latex?	26.	Yes	No	Thyroid, adrenal disease?
	Please list allergies:_____						
11.	Yes	No	Family history of diabetes, heart problems, tumors? _____				
12.	Yes	No	Psychiatric care?	27.	Yes	No	Hospitalization?
13.	Yes	No	Radiation treatment?	28.	Yes	No	Blood transfusion?
14.	Yes	No	Chemotherapy?	29.	Yes	No	Surgeries?
15.	Yes	No	Prosthetic heart valve?	30.	Yes	No	Pacemaker?
16.	Yes	No	Artificial joint?	31.	Yes	No	Contact lenses?

Are you taking (circle all that apply): Tobacco in any form, Alcohol, Recreational Drugs? List:_____
Are you taking (circle all that apply) Drugs, medications, over-the-counter medicines (including aspirin), natural remedies?
Please list:_____ _____
WOMEN ONLY: Are you or could you be pregnant or nursing? Please explain:_____
Do you have any other diseases or medical problems NOT listed on this form? If so, please explain:
_____
To the best of my knowledge, I have answered ever question completely and accurately. I will inform my dentist of any change in my health and/or medication.
Patient's signature:_____ Date:_____

Doctor's signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

*You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Print Name

_____ _____

Signature Date

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barrier prohibited obtaining acknowledgement

____ An emergency situation prevented us from obtaining acknowledgment

____ Other: _____

Staff Member Signature: _____

Date: _____

HIPAA RELEASE & COMMUNICATION PREFERENCES

Name: _____ Date of Birth: ____/____/____

We are unable to discuss your treatment with anyone unless you give us written permission.

Please select your preferences below with an X:

I authorize the release of information including the diagnosis, records, images, treatment rendered to me and account and claims information. This information may be released to the following: (Please note: Certain treatments may require patient to be sedated. You will need to have a driver. Your driver must be listed on this medical information release form prior to treatment.)

My general and/or referring dentist Names: _____

Spouse name: _____

Children(s) name(s): _____

Parent name: _____

Other name: _____

Information is not to be released to anyone _____

The release of information will remain in effect until terminated by me in writing.

Please call my: Home Work Cell Phone #_____

If unable to reach me:

_____ You may leave a detailed message

_____ Please leave a message asking me to return your call

Other _____

Best time to reach me is (day) _____ between (time) _____

Patient Signature _____ Date ___/___/___

FACTS YOU SHOULD KNOW ABOUT DENTAL HEALTH

Dental Insurance is rapidly playing a larger and larger role in helping people obtain dental treatment. Since we strongly feel our patients deserve the best possible care we can provide, and in an effort to maintain the highest quality of care, we would like to share some facts about dental insurance with you.

Fact #1 - Dental Insurance is meant to assist you in the payment of your dental care, but rarely covers all of the treatment of services that your specific treatment might require.

Fact #2 Many routine dental services are NOT covered by insurance carriers, although they may be necessary.

Fact #3 - Many plans state that you will be covered “up to 50%, 0%, or 100%,” in spite of what you’re told, we’ve found in actuality that many plans may cover less that that depending on their established usual and customary fees. The benefits of your plan pays is largely determined by how much your employer/union paid for the plan. The less they paid for the insurance, the less benefit you will receive.

Fact #4 - Insurance companies’ established “usual and Customary” fee schedules may or may not have an accurate relationship to what is “usual and customary” fees for our region. It has been the experience of some dentists that some insurance companies tell their insured that their “fees are above the usual and customary fees” rather than saying to them that “our benefits are low” This may be so because there are various ways and calculations by which the insurance companies will have different usual and customary fees for the same geographical region. The dentist’s fees may be within one company’s and not within another company’s usual and customary fees.

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read and understand all the information on this sheet. I understand that there will be an 18% finance charge on all balance after 60 days. I am aware that if an attorney or collection agency is employed to collect an unpaid balance, I am responsible for the applicable attorney or collection fees. **I understand and accept that a 24-hr notice of cancellation is necessary to avoid a charge of $25.00 for every hour that was scheduled for my treatment. In the event of 3 missed appointments with less than a 24 hour notice, Dental Ben’s has the right to dismiss you from the practice.**

_____ _____

Signature of Responsible Party Date