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?
10. Yes No Were you treated with the intravenous bisphosphonates for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer: If so when?
    ____
11. Yes NO Have you ever had orthodontic treatment? If so when? ______________
12. Yes No Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) or osteoporosis or Paget's disease?
13. Are you taking (circle all that apply): Tobacco in any form, Alcohol, Recreational Drugs?
    List:______________
14. Are you taking (circle all that apply)Drugs, medications, over-the-counter medicines (including aspirin), natural remedies? Please
    list:____
15. WOMEN ONLY: Are you or could you be pregnant or nursing? Please Do
    Explain:______________________
16. do you have any other diseases or medical problems NOT listed on this form? If so, please explain:
    ____
    ____

HAVE YOU EXPERIENCED:

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

DO YOU OR HAVE YOU HAD:

1. Yes No Heart Disease
2. Yes No Heart Attack, Heart Defects?
3. Yes No Heart murmurs?
4. Yes No Rheumatic fever?
5. Yes No Stroke, hardening of arteries
6. Yes No High Blood Pressure
7. Yes No Asthma, TB, Emphysema, other lung diseases?
17. Yes No HIV?
18. Yes No AIDS?
19. Yes No Arthritis, rheumatism?
20. Yes No Eye diseases?
21. Yes No Skin diseases?
22. Yes No Anemia?
23. Yes No Venereal Disease?

Patients name: ____

Health History Continue: Page 2

8. Yes No Hepatitis, other liver disease?

9. Yes No Stomach problems, ulcers?

10. Yes No Psychiatric care?
11. Yes No Radiation treatment?
12. Yes No Chemotherapy?
13. Yes No Prosthetic heart valve?
14. Yes No Artificial joint?
15. Yes No Latex Allergie

16. Yes No Thyroid, adrenal disease?

17. Yes No Mitral Valve Prolapse?

18. Yes No Allergies to: Drugs, foods, Medication?

Please list allergies:____

19. Any Family History of:

Yes No Tumors Yes No Cancer Yes No Artritis

Yes No Heart attacks Yes No Diabetes

Yes No High Blood Pressure Yes No Low Blood Pressure

Any other family history? Please list:

____

24. Yes No Herpes?

25. Yes No Kidney, bladder disease?

27. Yes No Hospitalization?
28. Yes No Blood transfusion?
29. Yes No Surgeries?
30. Yes No Pacemaker?

31. Yes No Contact lenses?

32. Yes No Gout

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forty above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any action taken or not taken because of errors or omissions that I may have made in the completion of this form.

Signature of Patient: ____Date: ____________________

Signature of Parent/Legal Guardian: ___________________________________Date: _____________________

Doctors 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