Office Staff Use

Patient Interests _____

_____

Hobbies _____

Vacations _____

Children/Family _____

Pets _____

Friends _____

Work _____

School _____

Bender **Dental** Group

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 Information (CONFIDENTIAL)

DATE _____

Name _____ *Birthdate* _____ *SS#* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Home Phone _____ *Cell Phone* _____ *E-mail* _____

Check appropriate Box: ☐*Minor* ☐*S* ☐*M* ☐*D* ☐*W* ☐*Separated* *Occupation* _____

If full time student, name of College _____ *State/City* _____

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

Business Address _____ *City* _____ *State* _____ *Zip* _____

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

Person to Contact in Case of Emergency _____ *Phone* _____

How did you hear about our practice? _____

Responsible Party

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

Address _____ *Home Phone* _____

Employer _____ *Work Phone* _____ *SS#* _____

Is this Person Currently a Patient in our Office? ☐*Yes* ☐*No*

Patient portion is expected at time of service. We offer the following methods of payment. Please check the option you prefer.

☐*Cash* ☐*Personal Check* ☐ *Bank Card* ☐*Visa* ☐*MasterCard* ☐*Discover*

☐*I wish to discuss the office's payment policy.*

Insurance Information (Dental)

Name of Subscriber _____ *Patient is:* ☐*Self* ☐*Spouse* ☐*Child*

Birthdate _____ *SS#* _____ *Ins. effective Date* _____

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

Address of Employer _____ *City* _____ *State* _____ *Zip* _____

Insurance Company _____ *Group #* _____ *ID#* _____

Ins. Co. Address _____ *City* _____ *State* _____ *Zip* _____

How Much is your Deductible? _____ *Max. Annual Benefit* _____

Over Please

Patient Dental History

Reason For Present Visit _____

	Yes	No
1. Are any of your teeth sensitive or painful?	☐	☐
2. Has this pain interfered with sleep?	☐	☐
3. Do your gums bleed when brushing or flossing?	☐	☐
4. Have you had any head, neck or jaw injuries?	☐	☐
5. Do you have any lumps or sores in or near your mouth?	☐	☐
6. Have you ever had extractions or (prolonged) bleeding following extractions? (Dates _____)	☐	☐
7. Do you like your smile?	☐	☐
8. Have you ever had orthodontic treatment?	☐	☐
9. Do you wear dentures or partials (dates)?	☐	☐
10. Do you have frequent headaches?	☐	☐
11. Do you clench or grind your teeth?	☐	☐
12. Have you ever experienced any of these jaw problems:		
• Clicking or Popping	☐	☐
• Pain (joint, ear, face)	☐	☐
• Difficulty opening or closing	☐	☐
• Difficulty chewing	☐	☐
13. Is your mouth frequently dry?	☐	☐

Last **DENTIST** & Location _____

Last Professional Cleaning _____

Last Cavity Detection X-Rays _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Have you ever taken or are you currently taking Fosamax, Zometa, Actonel, Aredia, Boniva or other bisphosphonates?	☐	☐
4. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Do you have or have you had any of the following?		

9. Are you **allergic** to or have you had any reactions to the following?

	Yes	No
Latex Rubber	☐	☐
Jewelry or Metal allergies	☐	☐
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other (please list)	☐	☐

10. Do you have a persistent cough or throat clearing not associated with known illness (lasting more than 3 weeks)?	☐	☐
11. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

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

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 such dental care to third party payors 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.

X _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____