

<i>Office Staff Use</i>
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		Yes	No
1. Are any of your teeth sensitive or painful?	<input type="checkbox"/>	<input type="checkbox"/>	7. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has this pain interfered with sleep?	<input type="checkbox"/>	<input type="checkbox"/>	8. Have you ever had orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do your gums bleed when brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you wear dentures or partials (dates)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any lumps or sores in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	11. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had extractions or (prolonged) bleeding	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever experienced any of these jaw problems:		
following extractions? (Dates _____) ..	<input type="checkbox"/>	<input type="checkbox"/>	• Clicking or Popping.....	<input type="checkbox"/>	<input type="checkbox"/>
Last DENTIST & Location _____			• Pain (joint, ear, face)	<input type="checkbox"/>	<input type="checkbox"/>
Last Professional Cleaning _____			• Difficulty opening or closing	<input type="checkbox"/>	<input type="checkbox"/>
Last Cavity Detection X-Rays _____			• Difficulty chewing.....	<input type="checkbox"/>	<input type="checkbox"/>
			13. Is your mouth frequently dry?	<input type="checkbox"/>	<input type="checkbox"/>

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	9. Are you allergic to or have you had any reactions to the following?		
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain _____			Jewelry or Metal allergies	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever taken or are you currently taking Fosamax, Zometa, Actonel, Aredia, Boniva or other bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you taking any medication(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have or have you had any of the following?			Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Yes No			Other (please list).....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you have a persistent cough or throat clearing not associated with known illness (lasting more than 3 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	11. Women Only:		
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	c) Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Yes No		
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded.....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement or Implant.....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequently Tired.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>			
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis/Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>			
Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>			
Stomach Troubles/Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>			

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 _____

Appointment Policy

It is our commitment to provide you with a wide range of appointment times to accommodate your schedule. In order to keep a variety of convenient times available, we ask for a minimum of 2 business days notice to change or cancel an appointment. Calling in advance allows us to offer the time to another patient in need of care. A fee of \$50.00 may be charged for all appointments that are not cancelled with 2 business days notice or for failing to show for an appointment. Your signature indicates you are aware and understand the terms of our appointments policy.

Patient/Responsibility Party

Signature _____ Date _____

Reviewed By _____ Date _____

FINANCIAL POLICY

As a courtesy to our patients, Bender Dental Group submits billable charges to insurance companies. Patient portion is due at time of service. If you have a balance after the insurance payment is received, that portion is due in full at that time. Please be prepared to pay your responsibility for today's visit and/or any prior balance. For your convenience we accept cash, checks and most major credit cards. We also offer Care Credit and Wells Fargo Health, (interest-free loans) to our qualifying patients as a payment option. If you need to consider other options, our front desk personnel will be happy to discuss this with you. When scheduling, an estimate can be given each time so that you can be prepared for each visit.

Returned checks: There is a fee (currently \$25) for any checks returned by the bank. There may be an additional fee for the service of presenting the check again as funds are available.

Past due accounts: If your account needs to be referred to a collection agency, all collection costs incurred will be your responsibility.

If you have any questions regarding the financial policy of the office, our front desk personnel will be happy to assist you.

Patient

Date

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice is available upon request.

Effective Date: Immediately

This information is made available on request by a patient

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

For medical treatment	For research
To obtain payment for our services	To avert a serious threat to health or safety
In emergency situations	For organ and tissue donation
For appointment and patient recall reminders	For workers' compensation programs
To run our Practice more efficiently and ensure all our patients receive quality care	In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint. You have certain rights regarding the information we maintain about you. These rights include:

The right to inspect and copy	The right to request restrictions
The right to amend	The right to a paper copy of this notice
The right to an accounting of disclosures	The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices that follows this summary.

Signature

Date