Welcome

Thank You For Selecting Our Dental Team!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Patient Information (Confidential)

Date ____________________

Name: ____ I prefer to be called: ______________________________

Address: __________________________________ City: ____________________ State: __________ Zip: ________

Phone: Home: (____) ____ - _____ Work: (____) ____ - _____ Ext: _______ Cell: (____) ____ - _____

E-Mail: __________________________ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Birthdate: __________________ Age: ______ Social Security #: ______________ D.L.#: __________________

If patient is a student, name of school/college: __________________ City: ______________ State: _____ ☐ Full Time ☐ Part Time

Employer: ______________________ Employer's Address: ____

How long there? __________ Occupation: ______________ Where & when are the best times to reach you: ______________

Previous/Present Dentist: ______________ Last visit date: ______________ Other family members seen by us: ______________

How did you hear about us?: ☐ Ameritech Yellow Pages ☐ Church Directory ☐ Inside Granger ☐ Radio/TV ☐ Sign

☐ Web site ☐ Other: ______________ Referred by: __________________________

Your personal physician's name: __________________________ Phone #: (____) ____ - _____ Last Visit Date: __________

Person to contact in case of emergency: ______________ Relation: __________ Phone: Hm: (____) ____ - _____ Wk: (____) ____ - _____

Responsible Party *(If different than above)*

Name: ____ Relation: ______________ Social Security #: __________

Address: ____ City: ______________________ Zip: __________

Phone: Home: (____) ____ - _____ Work: (____) ____ - _____ Ext: _______ Employer: __________________________

Insurance Information

Insurance Company Name: __________________ Address: ____________________________ Phone #: ______________

Insured's Employer: ______________________ Group #(Plan or Policy #): __________________

Insured's Name: ______________________ Relation: __________ Insured's birthdate: ____________ Insured's SSN: __________

Do you have secondary insurance?: ☐ Yes ☐ No If yes, complete the following:

Insurance Company Name: __________________ Address: ____________________________ Phone #: ______________

Insured's Employer: ______________________ Group #(Plan or Policy #): __________________

Insured's Name: ______________________ Relation: __________ Insured's birthdate: ____________ Insured's SSN: __________

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed carriers and assign directly to Bruce P. Benifiel, DDS, PC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities deemed necessary by this office. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance.

______________________________ ______________________ ______________________

Responsible Party Signature Relationship Date

Medical History

Have you ever had any of the following diseases or medical problems?

Abnormal bleeding	☐ Yes	☐ No	Difficulty breathing	☐ Yes	☐ No	Low blood pressure	☐ Yes	☐ No
Alcohol/Drug abuse	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Mitral valve prolapse	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Fainting Spells	☐ Yes	☐ No	Psychiatric problems	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No	Frequent headaches	☐ Yes	☐ No	Radiation treatment	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart attack	☐ Yes	☐ No	Scarlet fever	☐ Yes	☐ No
Blood disease	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Blood transfusion	☐ Yes	☐ No	Heart Surgery	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hepatitis, Type________	☐ Yes	☐ No	Sinus problems	☐ Yes	☐ No
Circulatory problems	☐ Yes	☐ No	Herpes/Fever Blisters	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Congenital heart defect	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Cortisone treatments	☐ Yes	☐ No	HIV+/AIDS	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No	Venereal disease	☐ Yes	☐ No

Please explain any "yes" answers:____

Please list any medications you take including over the counter drugs:____

____

Are you allergic to: ☐ Penicillin ☐ Erythromycin ☐ Tetracycline ☐ Codeine ☐ Sulfa ☐ Aspirin ☐ Latex ☐ Dental Anesthetics

☐ Other: ______________________________ Pharmacy: ____________________ Phone: (____)____ - _____

Dental History

Why have you come to the dentist today?:____

Do you require antibiotic pre-medication prior to dental treatment?: ☐ Yes ☐ No If yes, why?:____________________

Are you currently in pain? ☐ Yes ☐ No

Have you had a previous bad dental experience? ☐ Yes ☐ No Are you apprehensive about dental treatment? ☐ Yes ☐ No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Financial Policies

In order to accept your insurance as payment, we will debit your credit card automatically for any remaining balance after insurance has paid. If you like us to accept your insurance, please provide your credit card information:

Circle One: VISA MASTERCARD DISCOVER

Account #______________________________ CVV2#________ Expires____________ Name on Card______________________

Our credit policies have been established to ensure that the best services can be provided to you and your family and any misunderstanding can be avoided. Our professional services are rendered to the patient and not to the insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor. We will not provide services on the assumption that the charges will be paid for by the insurance company. With or without insurance coverage, you are responsible for full payment of your total bill. Payment is due and payable as services are rendered. For your convenience, we offer payment plans administered by Care Credit.

I understand that the information that I have given today is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I understand the financial policies above and agree to comply with them. I agree that parents are responsible for all fees and services rendered for treatment of a child. I understand that I am responsible for all fees regardless of insurance coverage. I authorize this office to charge my credit card to cover any unpaid fees not paid by insurance within 60 days. I understand that check payments may be converted to automatic bank drafts. I understand that in certain circumstances, my credit report may be requested. All accounts with balances over 60 days are subject to a 2% (24% APR) service charge. In the event that my payments are not received within 60 days of their due date, I agree to pay all costs of collection, including, but not limited to, reasonable attorney's fees.

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

______________________________ ______________________

Patient or Responsible Party Signature Date