WELCOME
Dr. Ben Kaseff DMD
2009

PATIENT INFORMATION

Date_____ Soc. Sec. #_____ Birthdate_____
Name_____
Last Name First Name Initial Nickname
Address_____Home Phone_____
City_____ State_____ Zip_____
Sex □ M □ F □ Minor □ Single □ Married □ Divorced □ Widowed □Separated
Employer _____ Business Phone _____
Business Address_____ Occupation_____
Other Phone Numbers (Cell/Pager) _____ E-Mail_____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____Phone_____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate_____ Soc. Sec. #_____
Address _____ Home Phone _____
City _____ State_____ Zip _____
Responsible Party Employed By _____ Business Phone_____
Business Address _____ Occupation_____
Insurance Company _____ Insurance Phone_____
Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. #_____
Address _____ Home Phone_____
City _____ State_____ Zip _____
Insured Party Employed By _____ Business Phone_____
Insurance Company _____ Insurance Phone _____
Subscriber I.D. # _____ Group # _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. Ben Kaseff DMD for all insurance benefits otherwise payable to me for services rendered. I understand that my insurance is an agreement between my insurance company and me. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I understand that I may incur a finance charge if my balance goes beyond 90 days.
I authorize the above doctor and/ or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
It is our policy to file your claim to the insurance company for you at no charge. The estimated insurance difference (EID) is due at the time of your visit. If there is no dental insurance available, payment is due in full at the time of service.

Please continue on the other side

MEDICAL & DENTAL HISTORY

DENTAL HISTORY:

Name:_____Chief Complaint:_____
Previous Dentist _____ Frequency and Type of Care_____

Have you had previous periodontal treatment? □ **Yes** □ **No** If yes, when? _____
Dr's Name _____ Have you had orthodontic treatment**?** □ **Yes** □ **No**
Are you satisfied with your dental appearance**?** □ **Yes** □ **No** Recent Tooth Loss _____
Have any of your teeth changed position in recent years? □ **Yes** □ **No** If yes, which ones?_____
Do you grind or clench your teeth**?** □ **Yes** □ **No** Jaw difficulty including clicking and/or pain □ **Yes** □ **No**
Are your teeth sensitive to hot or cold**?** □ **Yes** □ **No** Are your teeth sensitive to biting pressure? □ **Yes** □ **No**
Do you have /get blisters on your lips or mouth? □ **Yes** □ **No**

MEDICAL HISTORY:

Physician's Name_____ Date of last visit _____
Have you or are you currently taking any of the following medications: Actonel, Boniva, Didronel, Fosamax, Skelid, (oral)
Aredia, Zometa (intravenous)

		Yes	No
1	Are you currently under medical treatment	□	□
2.	Have you ever had any serious illness Operations	□	□
3.	Have you used or taken any drugs or Medications in the last six months? Please describe: _____ _____ _____ _____	□	□
4.	Do you smoke?	□	□
5.	Do you use alcohol?	□	□
6.	Do you use cocaine or other drugs	□	□
7.	Are you allergic or sensitive to any medications? If yes what? _____ _____ _____ _____	□	□
8.	(**Women Only**) Are You: Pregnant? If yes, #_____wks	□	□
	Nursing?	□	□
	Taking birth control pills?	□	□

Do you have or have you ever had any of the following?

	Y	N		Y	N		Y	N
Aids/HIV	□	□	Fainting or Dizziness	□	□	Rheumatic Fever	□	□
Arthritis, Rheumatism	□	□	Glaucoma	□	□	Scarlet Fever	□	□
Artificial Heart Valves	□	□	Headaches	□	□	Seizures/Epilepsy	□	□
Artificial Joints	□	□	Heart Murmur	□	□	Shortness of Breath	□	□
Asthma	□	□	Heart Problems	□	□	Sinus Trouble	□	□
Bleeding Abnormally/			Hepatitis-Type ___	□	□	Skin Rash	□	□
Hemophilia	□	□	Herpes	□	□	Stroke	□	□
Blood Disease	□	□	High Blood Pressure	□	□	Swelling of Feet/Ankles	□	□
Cancer	□	□	Jaundice	□	□	Swollen Neck Glands	□	□
Chemical Dependency	□	□	Kidney Disease	□	□	Thyroid Problems	□	□
Chemotherapy	□	□	Latex Sensitivity	□	□	Tuberculosis	□	□
Circulatory Problems	□	□	Liver Disease	□	□	Tumor or growth	□	□
Congenital Heart Lesions	□	□	Low Blood Pressure	□	□	head/neck		
Diabetes	□	□	Nervous Problems	□	□			
Digestive Problems	□	□	Pacemaker	□	□			
Emphysema	□	□	Radiation Treatment	□	□			
Mitral Valve Prolapse	□	□	Respiratory Disease	□	□			

I certify that the above information is correct to the best of my knowledge.

It is our goal to provide excellent patient care in a relaxed and caring setting. Appointment times are exclusively reserved for each patient. For this reason, we require 48 hours advance notice on all schedule changes or cancellations. We reserve the Right to apply a broken appointment fee for changes made with less than 48 hours notice.
I have read and understand the above policy.

*Signature*_____ *Date*_____

Medical/Dental Summary-Risk assessment: □ No special considerations necessary □ Special considerations as follows:_____
_____

*Dental Provider Signature:*_____ *Date:* _____