WELCOME TO BENCHMARK DENTAL

DATE_____

FIRST NAME_____

LAST NAME_____

MIDDLE INITIAL_____

ADDRESS_____

CITY_____STATE____ZIP_____

EMAIL_____

SS# OR ID#_____

SEX: M ☐ F ☐

BIRTHDATE_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

_____

MARRIED	WIDOWED	SINGLE
SEPERATED	DIVORCED	PARTNERED

OCCUPATION_____

CELL PHONE_____

HOME PHONE_____

WORK PHONE_____

PATIENT EMPLOYER/SCHOOL_____

EMPLOYER PHONE_____

SPOUSE INFORMATION:

SPOUSE'S NAME_____

SPOUSE'S BIRTHDATE_____

SPOUSE SS#_____

SPOUSE'S EMPLOYER_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

_____

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR ACCOUNT?_____

RELATIONSHIP TO PATIENT_____

INSURANCE COMPANY_____

GROUP#_____

IS PATIENT COVERED BY ADDITIONAL INSURANCE?_____

SUBSCRIBERS NAME_____

BIRTHDATE_____SS#_____

RELATIONSHIP TO PATIENT_____

INSURANCE COMPANY_____

GROUP#_____

ASSIGNMENT AND RELEASE

I certify that I have read, understand, and agree with the Benchmark Dental Financial Policy, and am bound by all legal practices therein.

(SIGNATURE)_____

I certify that I have read, understand, and agree with HIPPA Notice of Privacy Practices.

(SIGNATURE)_____

I certify that I have read, understand, and agree with the Benchmark Dental Cancellation Policy.

(SIGNATURE)_____

DENTAL AND HEALTH HISTORY

PLEASE CIRCLE "YES" OR "NO" REGARDING THE FOLLOWING QUESTIONS

DO YOU USE TOBACCO?	YES	NO	PREGNANT OR NURSING?	YES	NO	DO YOU HAVE CROOKED TEETH?	YES	NO
AMOUNT CONSUMED (X/DAY)_____			IF YES, WHAT TRIMESTER?_____			INTERESTED IN ORTHODONTICS?	YES	NO
BAD BREATH	YES	NO	CHEMOTHERAPY	YES	NO	SKIN RASH	YES	NO
BLEEDING GUMS	YES	NO	CIRCULATORY PROBLEMS	YES	NO	SPECIAL DIET	YES	NO
BLISTERS ON LIPS/MOUTH	YES	NO	HEART PROBLEMS	YES	NO	STROKE HISTORY	YES	NO
DRY MOUTH	YES	NO	PERISTANT/BLOODY COUGH	YES	NO	SWOLLEN NECK GLANDS	YES	NO
GRINDING OF TEETH	YES	NO	DIABETES	YES	NO	THYROID PROBLEMS	YES	NO
LOOSE TEETH	YES	NO	EMPHYSEMA	YES	NO	TONSILITIS	YES	NO
BROKEN FILLINGS	YES	NO	EPILEPSY	YES	NO	TUBERCULOSIS	YES	NO
MOUTH PAIN	YES	NO	FAINTING/DIZZIENESS	YES	NO	TUMOR/GROWTH ON HEAD	YES	NO
ORTHODONTIC TREATMENT	YES	NO	GLAUCOMA	YES	NO	ULCER	YES	NO
SENSITIVITY TO COLD	YES	NO	HEADACHES	YES	NO	VENEREAL DISEASE	YES	NO
SENSITIVITY TO HEAT	YES	NO	HEART MURMUR	YES	NO	UNEXPLAINED WEIGHT LOSS	YES	NO
SENSITIVITY TO SWEETS	YES	NO	HEPATITIS (TYPE?)	YES	NO	TAKING BLOOD THINNERS	YES	NO
SENSITIVITY TO BITING	YES	NO	HERPES	YES	NO	**PLEASE LIST CURRENT MEDICATIONS**		
SORES IN YOUR MOUTH	YES	NO	HIGH BLOOD PRESSURE	YES	NO	_____		
GROWTHS IN YOUR MOUTH	YES	NO	JAW PAIN	YES	NO	_____		
TAKEN "FEN-PHEN"	YES	NO	KIDNEY DISEASE	YES	NO	_____		
AIDS/HIV	YES	NO	LIVER DISEASE	YES	NO	_____		
ANEMIA	YES	NO	MITRAL VALVE PROLAPSE	YES	NO	**ALLERGIES**		
ARTIFICIAL HEART VALVES	YES	NO	ANXIETY	YES	NO	**ASPIRIN**	**PENICILLIN**	
ARTIFICIAL JOINTS	YES	NO	PACEMAKER	YES	NO	**BARBITUATES**	**SULPHA**	
ASTHMA	YES	NO	PSYCHIATRIC CARE	YES	NO	**CODIENE**	**METALS**	
BACK PROBLEMS	YES	NO	RADIATION TREATMENT	YES	NO	**OPIATES**	**IODINE**	
ABNORMAL BLEEDING	YES	NO	REPIRATORY DISEASE	YES	NO	**LATEX**	**OTHER:**	
BLOOD DISEASE	YES	NO	RHEUMATIC FEVER	YES	NO	_____		
CANCER HISTORY	YES	NO	SCARLET FEVER	YES	NO	_____		
CHEMICAL DEPENDENCY	YES	NO	SINUS TROUBLE	YES	NO	_____		

PLEASE INDICATE ANY MEDICAL OR DENTAL PROBLEMS OR CONDITIONS NOT MENTIONED ABOVE:

SIGNATURE OF PATIENT/GUARDIAN:_____ **DATE:**_____