EXCELLENCE IN DENTISTRY

# 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 complete this form (use ink). If you have any questions or need assistance, please ask us we will be happy to help.

## Patient Information (Confidential)

Today's Date _____/_____/_____

Name_____ Birthday____/_____/_____ SSN_____-_____-_____

Address _____ City_____ State _____ Zip_____

Email _____ Home Phone (  ) _____ Cell Phone (  ) _____

*Please circle the best daytime phone number*

Circle: MALE or FEMALE  Check Status: ___Minor ___Single ___Married ___Divorced ___Widowed___Separated

If Student, Name of School/College _____ City _____State_____

Patient or Parent/Guardian's Employer_____ Work Phone (  ) _____

Business Address _____City_____ State_____ Zip _____

Spouse/Parent/Guardian's Name_____ Employer_____ Work Phone (  ) _____

Whom may we thank for referring you?  Where have you heard about us? *Please check ALL that apply:*

☐ Friend/Family_____ ☐ TV/Radio ☐ Website ☐ Facebook/Twitter ☐ Event ☐ Newspaper

*(Name)*

Person to contact in case of emergency: _____ Phone (  ) _____

Have you been told by a physician that you need an antibiotic PREMED before receiving any dental treatments? ☐ YES ☐ NO

If yes, what medication is recommended by your doctor? _____

For what medical conditions? _____

Have you ever had Botox or dermal fillers? ☐ YES ☐ NO

## Responsible Party

Person Responsible for this Account _____ Relationship to Patient _____

Address_____ Home Phone (  ) _____

Email _____ Cell Phone (  ) _____

Driver's License# _____ Birthday _____/_____/_____ SSN _____-_____-_____

Employer_____ Work Phone (  ) _____

Is this person a patient in our office: ☐ YES ☐ NO

## Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthday _____/_____/_____ SSN _____-_____-_____ Date Employed _____/_____/_____

Name of Employer _____ Work Phone (  ) _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy ID # _____

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

Ins. Phone Number _____

## Payment - Insurance Authorization

*A $25.00 rebilling fee will be charged for each month your balance is overdue. A balance is overdue if not paid within 60 days from the DATE OF SERVICE, regardless of insurance coverage. I understand that any legal fees incurred by this office in collection of the accounts balance will be my responsibility. For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full expected at each appointment.*

*By signing below, I authorize the Office of Mark T. Bentley D.D.S., Inc., to release any information relating to my claim and I authorize payment from my insurance company to be made directly to Mark T. Bentley D.D.S., Inc. I authorize Mark T. Bentley DDS, Inc. or his agent to obtain and verify a credit report. I also understand that all fees not paid by insurance are my responsibility.*

☐ *Cash* ☐ *Personal Check* ☐ *Visa* ☐ *MasterCard* ☐ *Discover* ☐ *American Express* ☐ *Care Credit*

**X Patient's Signature** _____

*If you are completing this form for another person, please sign below and indicate your relationship to the patient.*

Signature _____ Relationship _____

| UDPDATED BY PATIENT | ADMIN USE ONLY | CLINICAL USE ONLY | OFFICE USE ONLY |
|---|---|---|---|
| 2) ____/____/____ _____ Date Your Initials | ____/____/____ ____ | ____/____/____ ____ | DATE ____/____/____ |
| 3) ____/____/____ _____ Date Your Initials | ____/____/____ ____ | ____/____/____ ____ | Acct #_____ |
| | ____/____/____ ____ Date Div I | ____/____/____ ____ Date Div IV | Revised 02/04/2016 |

*Please complete reverse side* ▶

**EXCELLENCE IN DENTISTRY**

# MEDICAL HISTORY

Today's Date_____/_____/_____

Patient Name_____Nickname_____Age_____

Name of Physician/and their specialty _____

Most recent physical examination_____ Purpose _____

What is your estimate of your general health? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

**DO YOU HAVE OR HAVE YOU EVER HAD:** *Please circle if applies*

1. Hospitalization for illness or injury..... Y N
2. An allergic reaction to:
   - Aspirin, ibuprofen, acetaminophen, codeine..... Y N
   - Penicillin..... Y N
   - Erythromycin..... Y N
   - Tetracycline..... Y N
   - Sulpha..... Y N
   - Local anesthetic..... Y N
   - Fluoride..... Y N
   - Metals (nickel, gold, silver, _____) Y N
   - Latex..... Y N
   - Other _____ Y N
3. Heart conditions present from birth (please list)..... Y N
   _____
4. Artificial heart valve..... Y N
5. History of infective Endocarditis..... Y N
6. Pacemaker or implantable defibrillator..... Y N
7. Artificial joints (please list) _____ Y N
   _____
8. Rheumatic or Scarlet Fever _____ Y N
9. Blood pressure: Y N
   - High _____
   - Low _____
10. A stroke (taking blood thinners) ..... Y N
11. Anemia or other blood disorders ..... Y N
12. Prolonged bleeding due to a slight cut (INR>3.5)..... Y N
13. Emphysema, Sarcoidosis..... Y N
14. Tuberculosis..... Y N
15. Asthma..... Y N
16. Breathing or sleep problems (i.e., snoring, sinus)..... Y N
17. Kidney disease..... Y N
18. Liver disease..... Y N
19. Jaundice..... Y N
20. Thyroid, parathyroid disease/calcium deficiency..... Y N
21. Hormone deficiency..... Y N
22. High cholesterol or taking Statin drugs..... Y N
23. Diabetes (HbA1c _____) Y N
24. Stomach or duodenal ulcer..... Y N
25. Digestive disorders (i.e., gastric reflux)..... Y N
26. Osteoporosis/Osteopenia (ie., taking bisphonsphonates) Y N
27. Arthritis ..... Y N
28. Glaucoma ..... Y N
29. Contact lenses ..... Y N
30. Head or neck injuries _____ Y N
31. Epilepsy, convulsions (seizures) _____ Y N
32. Neurologic Problems (attention deficit disorders) ..... Y N
33. Viral infections and cold sores ..... Y N
34. Any lumps or swelling in the mouth ..... Y N
35. Hives, skin rash, hay fever ..... Y N
36. Venereal disease ..... Y N
37. Hepatitis (type _____)..... Y N
38. HIV / AIDS ..... Y N
39. Tumor, abnormal growth ..... Y N
40. Radiation therapy ..... Y N
41. Chemotherapy ..... Y N
42. Emotional problems ..... Y N
43. Psychiatric treatment ..... Y N
44. Antidepressant medication ..... Y N
45. Alcohol / drug dependency ..... Y N
46. Cancer ..... Y N

**ARE YOU:**

47. Presently being treated for any other illness?..... Y N
    If YES, explain _____
48. Aware of a change in your general health?..... Y N
49. Taking medication for weight management (i.e. fen-phen) Y N
50. Taking dietary supplements ..... Y N
51. Often exhausted or fatigued ..... Y N
52. Subject to frequent headaches ..... Y N
53. Smoker or smoked previously (date you quit _____) Y N
54. Considered a touchy person ..... Y N
55. Often unhappy or depressed ..... Y N
56. FEMALE - taking birth control pills ..... Y N
57. FEMALE - pregnant ..... Y N
58. MALE - prostate disorders ..... Y N

**Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:**

_____

**List all medications, supplements, and/or vitamins taken within the last two years:**

| Drug | Purpose | Drug | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | Ask for an additional sheet if you are taking more than 7 medications. | |

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

**Patient's Signature** _____ DATE_____/_____/_____

Doctor's Signature _____ DATE_____/_____/_____

*Please complete reverse side*

Revised 02/04/2016