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Mark T. Bentley DDS, Inc.
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of **Mark T. Bentley DDS, Inc.** Notice of Privacy Practices, which has an effective date of **9/23/13**, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_______________________________________ _____________________
Signature of Patient or Patient's Representative **Date**

____
Print Name

____
Relationship to Patient (If not signed by the Patient)

If you are filling this form out for a minor, please print their name in the space provided. If you are filling this form out for yourself, please skip this section.

I acknowledge that I have received this Notice of Privacy Practices for the following ***minor*** family members:

Name____________________________________ Name____________________________________

Name____________________________________ Name____________________________________

Name____________________________________ Name____________________________________

I give my permission for this office to discuss my/my child's medical/dental/financial information with the following persons(s). This is optional, if there is someone you would like to include, please list below:

Name____________________________________ Relationship______________________________

Name____________________________________ Relationship______________________________

Name____________________________________ Relationship______________________________

DENTAL HISTORY

Referred by ____________________ How would you rate the condition of your mouth? □ Excellent □ Good □ Fair □ Poor
Previous Dentist __________________________ How long had you been a patient? _________ Months/Years
Date of most recent dental exam _______/______/_______ Date of most recent x-rays _____/______/_____
Date of most recent treatment (other than a cleaning) ______/______/______

I routinely see my dentist every: □ 3 mo. □ 4 mo. □ 6 mo. □ 12 mo. □ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE CIRCLE YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

1. Are you fearful of dental treatment? Scale of 1 to 10 (very)____ Y N
2. Have you had an unfavorable dental experience? ____ Y N
3. Have you ever had complications from past dental treatment? ____ Y N
4. Have you ever had trouble getting numb or reactions to local anesthetic? _______________________________ Y N
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____________________________ Y N
6. Have you had any teeth removed? ____ Y N

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _______________________ Y N
8. Have you ever whitened (bleached) your teeth? ____ Y N
9. Are you self conscious about your teeth? ____ Y N
10. Have you been disappointed with the appearance of previous dental work? ______________________________ Y N

BITE AND JAW JOINT

11. Do you have any problems chewing gum? ____ Y N
12. Do you have any problems chewing bagels or other hard foods? ______________________________________ Y N
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? __________________________ Y N
14. Are your teeth crowding or developing spaces? ____ Y N
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _______________ Y N
16. Do you have any problems with sleep or wake up with an awareness of your teeth? _______________________ Y N
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _______________ Y N
18. Do you have tension headaches or sore teeth? ____ Y N
19. Do you wear or have you ever worn a bite appliance? ____ Y N

TOOTH STRUCTURE

20. Have you had any cavities within the past 3 years? ____ Y N
21. Do you have a dry mouth? ____ Y N
22. Are any teeth sensitive to hot, cold, biting or sweets? ____ Y N
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? ________________________ Y N
24. Do you avoid brushing any part of your mouth? ____ Y N
25. Do you feel or notice any holes (i. e. pitting) in your teeth? ____ Y N

GUM AND BONE

26. Have you ever been diagnosed or treated for periodontal (gum) disease? ________________________________ Y N
27. Have you ever experienced gum recession? ____ Y N
28. Is there anyone with a history of periodontal disease in your family? ___________________________________ Y N
29. Do your gums bleed when brushing, flossing or eating? ____ Y N
30. Are your teeth becoming loose? ____ Y N
31. Have you ever noticed an unpleasant taste or odor in your mouth? ______________________________________ Y N
32. Have you experienced a burning sensation in your mouth? ____ Y N

Patient's Signature ____ Date _________________________

Doctor's Signature____ Date _________________________

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