



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 _____

UPDATED BY PATIENT	
2) ____/____/____	_____
Date	Your Initials
3) ____/____/____	_____
Date	Your Initials

ADMIN USE ONLY	
____/____/____	_____
____/____/____	_____
____/____/____	_____
Date	Div I

CLINICAL USE ONLY	
____/____/____	_____
____/____/____	_____
____/____/____	_____
Date	Div IV

OFFICE USE ONLY	
DATE ____/____/____	_____
Acct # _____	_____
Revised 02/04/2016	

Please complete reverse side

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 | 25. Digestive disorders (i.e., gastric reflux)..... | Y | N |
| 2. An allergic reaction to: | | | 26. Osteoporosis/Osteopenia (ie., taking bisphosphonates) | Y | N |
| Aspirin, ibuprofen, acetaminophen, codeine..... | Y | N | 27. Arthritis | Y | N |
| Penicillin..... | Y | N | 28. Glaucoma | Y | N |
| Erythromycin..... | Y | N | 29. Contact lenses | Y | N |
| Tetracycline..... | Y | N | 30. Head or neck injuries _____ | Y | N |
| Sulpha..... | Y | N | 31. Epilepsy, convulsions (seizures) _____ | Y | N |
| Local anesthetic..... | Y | N | 32. Neurologic Problems (attention deficit disorders) | Y | N |
| Fluoride..... | Y | N | 33. Viral infections and cold sores | Y | N |
| Metals (nickel, gold, silver, _____) | Y | N | 34. Any lumps or swelling in the mouth | Y | N |
| Latex..... | Y | N | 35. Hives, skin rash, hay fever | Y | N |
| Other _____ | Y | N | 36. Venereal disease | Y | N |
| 3. Heart conditions present from birth (please list)..... | Y | N | 37. Hepatitis (type _____) | Y | N |
| _____ | | | 38. HIV / AIDS | Y | N |
| 4. Artificial heart valve..... | Y | N | 39. Tumor, abnormal growth | Y | N |
| 5. History of infective Endocarditis..... | Y | N | 40. Radiation therapy | Y | N |
| 6. Pacemaker or implantable defibrillator..... | Y | N | 41. Chemotherapy | Y | N |
| 7. Artificial joints (please list) _____ | Y | N | 42. Emotional problems | Y | N |
| _____ | | | 43. Psychiatric treatment | Y | N |
| 8. Rheumatic or Scarlet Fever _____ | Y | N | 44. Antidepressant medication | Y | N |
| 9. Blood pressure: | Y | N | 45. Alcohol / drug dependency | Y | N |
| High _____ | | | 46. Cancer | Y | N |
| 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 | | | |

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 