Cooley-Bentz Dental Associates, P.C.
Sara Cooley-Bentz, DMD, FAGD
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PATIENT INFORMATION *CONFIDENTIAL*

Name: _____ Date _____
FIRST MIDDLE LAST

Address: _____
STREET CITY STATE ZIP

CONTACT INFORMATION

Home: _____ Work: _____
Fax: _____ Cell: _____
Email Address: _____
Best day/time to be reached: _____ Where? _____
In the event of an emergency, who should we contact?
Name: _____
Relationship: _____
Work # _____ Home #: _____

Birthdate: _____

Minor Patients – A parent/guardian must accompany minors when services are being performed in our office. This adult is responsible for payment regardless of family status.

Patient's or Parent's Employer: _____ Occupation: _____

Business Address: _____
STREET CITY STATE ZIP

Spouse or Parent's Name: _____ Employer: _____ Work Phone: _____

If patient is a student, name of school/college: _____ City: _____ State: _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____ Relationship: _____

Address: _____
STREET CITY STATE ZIP

Home Phone: _____ Soc. Sec. #: _____ Birthdate _____

Driver's License #: _____

Employer: _____ Work Phone: _____

Is this person currently a patient in our office? ❍ Yes ❍ No

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INSURANCE INFORMATION

Name of insured: _____ Relationship: _____

Birthdate: _____ Soc. Sec. # _____ Date Employed: _____

Employer: _____ Work Phone: _____

Address of Employer: _____
STREET CITY STATE ZIP

Insurance Company: _____ Group #: _____

Do you have any secondary insurance?: ❍ Yes ❍ No If yes, complete the following:

Name of insured: _____ Relationship: _____

Birthdate: _____ Soc. Sec. #: _____ Employer: _____

Address of Employer: _____ Work Phone: _____

Insurance company: _____ Group #: _____

FINANCES

Payment in full is expected at each appointment. We have scheduled time in our schedule just for you, therefore, we require 48 business hours notice for any cancellation. If you miss your appointment, that time could have been allotted for another patient in need. There is a $30 service charge on all returned checks. For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you.

❍ Cash
❍ Personal Check
❍ Visa
❍ MasterCard
❍ Discover
❍ American Express
❍ Care Credit

Card #: _____

Exp. Date: _____

_____
NAME AS IT APPEARS ON CARD

Authorization, Release, & Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or health practitioners.

As a courtesy, we will be glad to file insurance claims for you. Please note that insurance is a contract between you and your insurance company and we are not a party to that contract. You will be responsible to pay your first office visit in full, unless prior arrangements are made with our front desk staff.

I authorize and hereby request my insurance company to pay directly to the dentist for the dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

_____ _____
Signature of patient or parent if minor *Date*

PATIENT DENTAL HISTORY

PATIENT NAME _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	❍	❍
2. Are your teeth sensitive to hot or cold?	❍	❍
3. Are your teeth sensitive to sweet or sour liquids/foods?	❍	❍
4. Do you feel pain in any of your teeth?	❍	❍
5. Do you have any sores or lumps in or near your mouth?	❍	❍
6. Have you had any head, neck or jaw injuries?	❍	❍
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	❍	❍
b) Pain (joint, ear, side of face)?	❍	❍
c) Difficulty in opening or closing?	❍	❍
d) Difficulty in chewing?	❍	❍
8. Do you have frequent headaches?	❍	❍
9. Do you clench or grind your teeth?	❍	❍
10. Do you bite your lips or cheeks frequently?	❍	❍
11. Have you ever had any difficult extractions in the past?	❍	❍
13. Have you ever had prolonged bleeding following extractions?	❍	❍
12. Have you had any orthodontic work?	❍	❍
14. Have you ever had instruction on the correct method of brushing your teeth?	❍	❍
15. Have you ever had instructions on the care of your gums?	❍	❍

What is the reason for your visit today? _____

_____

Date of last dental visit _____ Previous Dentist _____

What was done at your last dental visit? _____

_____

Are you satisfied with your teeth's appearance? ❍ Yes ❍ No

What would you change about your smile? _____

Do you brush, floss or use any other dental aids? _____

Is there anything else about having dental treatment that you would like us to know? ❍ Yes ❍ No

If yes, please describe _____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____ _____

PATIENT, PARENT OR GUARDIAN **DATE**

MEDICAL HEALTH HISTORY

PATIENT NAME: _____ **DATE:** _____

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST PHYSICAL _____

HEIGHT _____ WEIGHT _____ INDICATE ANY PREMEDICATIONS _____

	YES	NO
1. Are you under medical treatment now? If yes, for what? _____	❍	❍
2. Have you ever been hospitalized for any surgical operation or serious illness? If yes, for what? _____	❍	❍
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s)/vitamins are you taking? _____	❍	❍
4. Do you use tobacco?	❍	❍
5. Do you use alcohol?	❍	❍
6. Do you use recreational drugs?	❍	❍

7. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
❍	❍	Local anesthetics	❍	❍	Sedatives	❍	❍	Iodine
❍	❍	Penicillin or other antibiotics	❍	❍	Food Allergies	❍	❍	Metal
			❍	❍	Codeine	❍	❍	Other
❍	❍	Sulfa drugs	❍	❍	Erythromycin			_____
❍	❍	Latex	❍	❍	Aspirin			_____

8. WOMEN ONLY:

	YES	NO
Are you pregnant or think you may be pregnant?	❍	❍
Are you nursing?	❍	❍
Are you taking birth control pills?	❍	❍

9. Do you <u>have</u> or <u>have you had</u> any of the following?

YES	NO		YES	NO		YES	NO	
❍	❍	Aids or HIV Infection	❍	❍	Frequently Tired	❍	❍	Liver Disease
❍	❍	Anemia	❍	❍	Glaucoma	❍	❍	Low Blood Pressure
❍	❍	Angina	❍	❍	Hay Fever/Allergies	❍	❍	Osteoporosis
❍	❍	Arthritis	❍	❍	Heart Attack	❍	❍	Radiation Therapy
❍	❍	Asthma	❍	❍	Heart Disease	❍	❍	Recent Weight Loss
❍	❍	Blood Transfusion	❍	❍	Heart Murmur	❍	❍	Respiratory Problems
❍	❍	Cancer	❍	❍	Heart Trouble	❍	❍	Rheumatic Fever
❍	❍	Cardiac Pacemaker	❍	❍	Hemophilia	❍	❍	Sexually Transmitted Disease
❍	❍	Chest Pains	❍	❍	Hepatitis/Jaundice	❍	❍	Shingles
❍	❍	Colitis	❍	❍	High Blood Pressure	❍	❍	Sleep Apnea
❍	❍	Diabetes Type I or II	❍	❍	High Cholesterol	❍	❍	Stomach Troubles/Ulcers
❍	❍	Easily Winded	❍	❍	Hyper/Hypo Thyroid	❍	❍	Stroke
❍	❍	Emphysema	❍	❍	Joint Replacement or Implant	❍	❍	Swollen Ankles
❍	❍	Epilepsy/Convulsions	❍	❍	Kidney Diseases	❍	❍	Tuberculosis
❍	❍	Fainting /Seizures	❍	❍	Leukemia	❍	❍	Other _____

COMMENTS _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered.
I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____ _____

PATIENT, PARENT OR GUARDIAN **DATE**

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