



BENSONHURST DENTAL CARE

# WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out these forms as completely as you can. We recommend that you use your keyboard and mouse to complete the form, print it, sign it and then mail it, fax it or bring it with you to your appointment. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health. Our mailing address is 1872 80th Street, Brooklyn, NY 11214 and our fax number is 718.234.3496.

## PATIENT INFORMATION

Name \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Email \_\_\_\_\_

## PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

## ADDITIONAL INSURANCE

Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Email \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_



## DENTAL HISTORY

What would you like us to do today? \_\_\_\_\_ Are you in dental discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Dentist's Email \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Check (X) yes or no if you have had problems with any of the following:

- Y  N Bad breath                       Y  N Food collection between teeth                       Y  N Periodontal treatment                       Y  N Sensitivity to sweets
- Y  N Bleeding gums                       Y  N Grinding or clenching teeth                       Y  N Sensitivity to cold                       Y  N Sensitivity when biting
- Y  N Clicking or popping jaw                       Y  N Loose teeth or broken fillings                       Y  N Sensitivity to hot                       Y  N Sores or growths in mouth

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Y  N

Other information about your dental health or previous treatment \_\_\_\_\_

## MEDICAL HISTORY

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations?  Y  N

If yes, describe \_\_\_\_\_

Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Y  N If yes, give approximate dates \_\_\_\_\_

Women: Are you pregnant?  Y  N Nursing?  Y  N Taking birth control pills?  Y  N

Have you ever taken Fen-Phen/Redux?  Y  N

Check (V) yes or no if you have had any of the following:

- Y  N AIDS/HIV Positive                       Y  N Cough, persistent                       Y  N Jaw pain                       Y  N Shingles
- Y  N Anaphylaxis                       Y  N Cough up blood                       Y  N Kidney disease or malfunction                       Y  N Shortness of breath
- Y  N Anemia                       Y  N Diabetes                       Y  N Liver disease                       Y  N Skin rash
- Y  N Arthritis, Rheumatism                       Y  N Epilepsy                       Y  N Material allergies (latex, wool, metal, chemicals)                       Y  N Spina Bifida
- Y  N Artificial heart valves                       Y  N Fainting                       Y  N Mitral valve prolapse                       Y  N Stroke
- Y  N Artificial joints                       Y  N Food allergies                       Y  N Nervous problems                       Y  N Surgical implant
- Y  N Asthma                       Y  N Glaucoma                       Y  N Pacemaker/Heart Surgery                       Y  N Swelling of feet or ankles
- Y  N Atopic (allergy prone)                       Y  N Headaches                       Y  N Psychiatric care                       Y  N Thyroid disease or malfunction
- Y  N Back problems                       Y  N Heart murmur                       Y  N Rapid weight gain or loss                       Y  N Tobacco habit
- Y  N Blood disease                       Y  N Heart problems                       Y  N Radiation treatment                       Y  N Tonsillitis
- Y  N Cancer                      Describe \_\_\_\_\_                       Y  N Rheumatic/Scarlet fever                       Y  N Tuberculosis
- Y  N Chemical dependency                       Y  N Hemophilia/Abnormal Bleeding                       Y  N Respiratory disease                       Y  N Ulcer/Colitis
- Y  N Chemotherapy                       Y  N Herpes                       Y  N Rheumatoid arthritis                       Y  N Venereal disease
- Y  N Circulatory problems                       Y  N Hepatitis                       Y  N Scurvy                       Y  N Syphilis
- Y  N Cortisone treatments                       Y  N High blood pressure                       Y  N Sickle cell anemia                       Y  N Tetanus

Is patient currently taking any medications? If yes, list all: \_\_\_\_\_

Does patient have drug allergies? If yes, list all. \_\_\_\_\_

## AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Payment is due in full at time of treatment unless prior arrangements have been approved.



## **Smile Evaluation Checklist**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

*To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer.*

- Do you dislike the color of your teeth? Yes  No
- Do you have spaces between your teeth that bother you? Yes  No
- Do you have chips or uneven edges on your teeth? Yes  No
- Do you feel that your teeth are too long or too short? Yes  No
- Do you have dark fillings that show when you smile? Yes  No
- Do your gums show too much when you smile? Yes  No
- Are your teeth crowded or crooked? Yes  No
- Do you have existing crowns or dental work that you consider "ugly"? Yes  No
- Are you self-conscious of your teeth and/or smile? Yes  No
- Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile? Yes  No
- Do you avoid smiling when you have your picture taken? Yes  No
- Would you like to improve your existing smile? Yes  No
- Do you wish you had a "new smile?" Yes  No

*What concerns do you have regarding dental treatment to improve your smile?*

- Fear of treatment
- Time of treatment concerns
- Financial concerns
- Distance to office
- Not understanding treatment
- Embarrassment
- Other

---

---

---