



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:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath              | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth  | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums           | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth    | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold   | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot    | <input type="checkbox"/> Y <input type="checkbox"/> 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:

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

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.**



CHECK ALL THAT APPLY:

**Medical problems**

- \_\_\_\_\_ [5 points] Cardiovascular disease (heart disease (coronary artery disease or congestive heart failure, irregular heart rhythm, heart valve problems (except mitral prolapse)) or history of heart surgery
- \_\_\_\_\_ [4] High blood pressure (even if effectively treated with medication)
- \_\_\_\_\_ [3] Neurologist problem (including stroke, Parkinson’s disease or multiple sclerosis) or chronic headaches
- \_\_\_\_\_ [2] Chronic lung disease or active smoking
- \_\_\_\_\_ [2] Attention deficit disorder or Chronic fatigue syndrome or Fibromialgia or Depression
- \_\_\_\_\_ [2] Chronic use of sleeping pills or narcotic pain medications

**Physical findings**

- \_\_\_\_\_ [2] Obesity (>10% above ideal body weight) or enlarged neck (> 17 inch (men), > 16 inch (women))
- \_\_\_\_\_ [2] Small mouth / throat (enlarged tonsils or significant overbite or small and “set-back” lower jaw or enlarged tongue)
- \_\_\_\_\_ [2] Chronic leg swelling (both legs) Signs or symptoms:
- \_\_\_\_\_ [5] Motor Vehicle accident or “near miss” attributable to falling asleep while driving or frequent sleepiness while driving
- \_\_\_\_\_ [5] Witnessed pauses in breathing during sleep or choking episodes during sleep
- \_\_\_\_\_ [3] Loud snoring
- \_\_\_\_\_ [3] Heartburn/ acid reflux awakening from sleep, or awakening from sleep, or awakening with a dry mouth or throat
- \_\_\_\_\_ [3] Frequently awakening tired or un refreshed or requiring a nap > 2 days per week
- \_\_\_\_\_ [2] Awakening more than 2 times per night (even to use a bathroom) or insomnia
- \_\_\_\_\_ [2] Prefer to avoid sleeping on your back
- \_\_\_\_\_ [1] Sleepwalking as an adult or prominent dreaming > 2 days per week

PLEASE REVIEW YOUR SCORE WITH YOUR DOCTOR

**Probability of Sleep Apnea:**

SCORE
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- 0-5 Sleep apnea possible, less likely
- 6-9 Suspicious for sleep apnea, further evaluation should be considered
- 10-14 Sleep apnea likely, further evaluation advised
- > 14 High risk for sleep apnea, evaluation strongly recommended

Note: This questionnaire should not represent a definitive diagnostic tool for ruling out sleep apnea, all medical decision should be made in a consultation with you physician.

**Please Fax This Form and A Prescription for any Sleep Studies to Slumber Services at 718 946 5502. Call Slumber Services at 718 946 5500 with any questions.**

Bensonhurst Dental Care  
1872 80<sup>th</sup> Street  
Brooklyn, NY 11214

## Notice of Privacy Practices Patient Acknowledgement

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A Statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to :
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not requires to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

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

Relationship to patient (if signed by a personal representative of patient): \_\_\_\_\_



## Appointment Policy

Dear Friend!

The time of your appointment is exclusively reserved for you.

We know there are things like flat tires, illness, and unforeseen circumstances. If you just let us know, we can help a drop-in patient or deal with a dental emergency instead.

If you are unable to keep your appointment, please give us at least 24 hours notice. This enables us to provide excellent and timely care for all patients. Failure to give us at least 24 hours notice may result in a \$95 broken appointment fee. We appreciate your understanding in this matter.

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Signature

Date

Very Truly Yours,

Bensonhurst Dental Care

Bensonhurst Dental Care PC  
1872 80<sup>th</sup> Street  
Brooklyn, NY 11214  
718.234.3434

Date \_\_\_\_\_

Your signature below indicate your consent for Bensonhurst Dental Care, PC, to use, reproduce and publish your comments about our practice and photographic and computer illustrations of your teeth and mouth for educational or marketing purposes. You also waive claim against any party based on the usage of the comments and images, or make any claim that the use of the comments and images defames you or constitutes an infringement of your rights to privacy, or any other right you may enjoy.

Patient's Signature \_\_\_\_\_

Patient's Name \_\_\_\_\_