BETHANY DENTAL ASSOCIATES
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WELCOME TO OUR OFFICE

To help us meet your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to assist you.

Patient Information (Confidential)

Date:_____

Name: _____ I preferred to be called: _____ ◯ Male ◯ Female
Last First M.I.

Birth date: _____ Age:_____ Social Security:_____ Driver License #:_____

Home Address:_____
Street City State Zip

Home Phone:(_____)_____ Cell Phone:(_____)_____ Email:_____

When confirming appointments how do you prefer to be contacted? (Check all that apply) ◯ Phone ◯ Email ◯ Text Message

Patient's or Parent's Employer:_____ Work Phone: (_____)_____

Employer Address:_____
Street/PO Box City State Zip

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

How did you hear about us? (Check all that apply) ◯ Internet ◯ Newspaper ◯ Insurance ◯ Personal Referral:_____

Pharmacy name & location: _____

Responsible Party (18+ you are your own Responsible Party)

Name of Person Responsible for this Account:_____ Relationship to Patient:_____

Birth date: _____ Social Security:_____ Contact Phone Number: (_____)_____

Employer:_____ Work Phone: (_____)_____ Is this individual a patient in our office? ◯ Yes ◯ No

For your convenience we offer the following methods of payment. Please check the option you prefer:

◯ Cash ◯ Personal Check ◯ Credit Card ◯ Care Credit (restrictions apply)

Insurance Information

Name of Insured:_____ _____ Relationship to Patient:_____

Insured's Birth date: _____ SSN:_____ Insured's Phone Number: (_____)_____

Name of Employer:_____ Union or Local #:_____ Work Phone: (_____)_____

Primary Insurance (Secondary Insurance can be given at the Front Desk)

Insurance Name:_____ Insurance Phone Number: (_____)_____

Insurance Address:_____
Street/PO Box City State Zip

Group Number: _____ Policy/ID Number:_____

Patient Medical History

General Physician/Specialist: _____ Office Phone: (_____)_____ Date of Last Exam:_____

	Yes	No
1. Are you under medical treatment now? If yes, please explain _____	◯	◯
2. Have you ever been hospitalized for any surgical operation within the last 5 years? If yes, please explain _____	◯	◯
3.Have you ever had a serious head or neck injury?	◯	◯
4. Are you taking any medication(s) including non-prescription medicine? If yes, please list _____	◯	◯
5. Do you take, or have you taken, Phen-fen or Redux?	◯	◯
6. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯	◯
7. Are you on a special diet?	◯	◯
8. Do you use Tobacco?	◯	◯

9. Are You Allergic to:	Yes	No
Local Anesthetics (ex. Novocain)	◯	◯
Penicillin	◯	◯
Other Antibiotics _____	◯	◯
Sulfa Drugs	◯	◯
Sedatives	◯	◯
Iodine	◯	◯
Aspirin	◯	◯
Ibuprofen	◯	◯
Tylenol	◯	◯
Codeine	◯	◯
Any Metals (ex. Nickel, Mercury, etc.) _____	◯	◯
Latex Rubber	◯	◯
Other_____	◯	◯
10. Women Only:		
a) Are you pregnant or think you may be pregnant?	◯	◯
b) Are you nursing?	◯	◯
c) Are you taking oral contraceptives	◯	◯

Do you have, or have you had, any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	◯	◯	Cortisone Medicine	◯	◯	Hemophilia	◯	◯	Radiation Treatments	◯	◯
Alzheimer's Disease	◯	◯	Diabetes	◯	◯	Hepatitis A	◯	◯	Recent Weight Loss	◯	◯
Anaphylaxis	◯	◯	Drug Addiction	◯	◯	Hepatitis B or C	◯	◯	Renal Dialysis	◯	◯
Anemia	◯	◯	Easily Winded	◯	◯	Herpes	◯	◯	Rheumatic Fever	◯	◯
Angina	◯	◯	Emphysema	◯	◯	High Blood Pressure	◯	◯	Rheumatism	◯	◯
Arthritis/Gout	◯	◯	Epilepsy or Seizures	◯	◯	High Cholesterol	◯	◯	Scarlet Fever	◯	◯
Artificial Heart Valve	◯	◯	Excessive Bleeding	◯	◯	Hives or Rash	◯	◯	Shingles	◯	◯
Artificial Joint	◯	◯	Excessive Thirst	◯	◯	Hypoglycemia	◯	◯	Sickle Cell Disease	◯	◯
Asthma	◯	◯	Fainting Spells/Dizziness	◯	◯	Irregular Heartbeat	◯	◯	Sinus Trouble	◯	◯
Blood Disease	◯	◯	Frequent Cough	◯	◯	Kidney Problems	◯	◯	Spina Bifida	◯	◯
Blood Transfusion	◯	◯	Frequent Diarrhea	◯	◯	Leukemia	◯	◯	Stomach/Intestinal Disease	◯	◯
Breathing Problem	◯	◯	Frequent Headaches	◯	◯	Liver Disease	◯	◯	Stroke	◯	◯
Bruise Easily	◯	◯	Genital Herpes	◯	◯	Low Blood Pressure	◯	◯	Swelling of Limbs	◯	◯
Cancer	◯	◯	Glaucoma	◯	◯	Lung Disease	◯	◯	Thyroid Disease	◯	◯
Chemotherapy	◯	◯	Hay Fever	◯	◯	Mitral Valve Prolapse	◯	◯	Tonsillitis	◯	◯
Chest Pains	◯	◯	Heart Attack/Failure	◯	◯	Osteoporosis	◯	◯	Tuberculosis	◯	◯
Cold Sores/Fever Blisters	◯	◯	Heart Murmur	◯	◯	Pain in Jaw Joints	◯	◯	Tumors or Growths	◯	◯
Congenital Heart Disorder	◯	◯	Heart Pacemaker	◯	◯	Parathyroid Disease	◯	◯	Ulcers	◯	◯
Convulsions	◯	◯	Heart Trouble/Disease	◯	◯	Psychiatric Care	◯	◯	Venereal Disease	◯	◯
									Yellow Jaundice	◯	◯

Have you ever had any serious illness not listed? ◯ Yes ◯ No If yes, please explain _____

_____

Patient Dental History

Name of Previous Dentist: _____ Phone: (_____) _____ Date of Last Cleaning/Exam:_____

Why have you come to the dentist today? _____

Your current dental health is: ◯ Good ◯ Fair ◯ Poor

Are you currently in pain? ◯ Yes ◯ No

Do you require antibiotics before dental treatment? ◯ Yes ◯ No

Do you floss daily? ◯ Yes ◯ No Brush Twice Daily? ◯ Yes ◯ No

Do you use an electric toothbrush? ◯ Yes ◯ No

Experience Bleeding? ◯ Yes ◯ No

Are your teeth sensitive to hot, cold, or anything else? ◯ Yes ◯ No

Do you have mobility in your teeth? ◯ Yes ◯ No

Have you ever had periodontal disease? ◯ Yes ◯ No

Do you still have wisdom teeth? ◯Yes ◯ No

Have you experienced difficult extractions in the past? ◯ Yes ◯ No

Have you experienced prolonged bleeding following extractions? ◯ Yes ◯ No

Do you now or have you ever experienced jaw joint pain? ◯ Yes ◯ No

Do you clench or grind your teeth? ◯ Yes ◯ No

Have you had any orthodontic treatment (braces, Invisalign)? ◯ Yes ◯ No

Do you wear dentures or partials? ◯ Yes ◯ No

If yes, date of placement_____

Are you happy with your smile? ◯ Yes ◯ No

If not, what would you like to change? _____

_____

Authorization and Release

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I agree to be responsible for payments of all service rendered on my behalf of my dependents.

Print Name of Patient or Authorized Representative:_____ **Signature:**_____ **Date**_____