MEDICAL/DENTAL HISTORY

Physician's name:__________ Address/City/zip:__________ Date:__________

When did you last consult a physician?__________ Reason: __________

Have you been a patient in a hospital in the past 2 years: ☐ Yes ☐ No Reason: __________

If new patient - name of former dentist:__________ Date of last examination:__________

What is your immediate dental problem?:__________

Do you use any tobacco products?__________

Do you have or have you had any of the following **(Please check and describe fully under remarks)**:

	Yes	No		Yes	No
1. Heart Disease	☐	☐	13. Radiation Treatment	☐	☐
2. High Blood Pressure	☐	☐	14. Liver or Kidney Disease	☐	☐
3. Blood Disease	☐	☐	15. Hepatitis, Jaundice	☐	☐
4. Rheumatic Fever	☐	☐	16. Allergies	☐	☐
5. Heart Murmur	☐	☐	a. Penicillin	☐	☐
6. Diabetes	☐	☐	b. Other Antibiotics	☐	☐
7. Stroke	☐	☐	c. Local Anesthetic	☐	☐
8. Epilepsy	☐	☐	d. Others	☐	☐
9. Fainting	☐	☐	17. Asthma	☐	☐
10. Psychiatric Treatment	☐	☐	18. Respiratory Disease	☐	☐
11. Arthritis	☐	☐	19. Does your jaw "click" or hurt?	☐	☐
12. Tumor History	☐	☐	20. Are you pregnant?	☐	☐

	Yes	No
Have you had any joint replacements?°	☐	☐
Have you ever been diagnosed with HIV, AIDS, or ARC.	☐	☐
Have you ever received I.V. (intra venous) treatment for cancer such as Zometa or Aredia	☐	☐
Have you been diagnosed with osteoporosis?	☐	☐
Have you had excessive bleeding requiring treatment?	☐	☐
Have you experienced any unfavorable reaction to previous medical or dental treatment?	☐	☐
Are you taking medicine, drugs or pills regularly?	☐	☐

Please list all medications you are taking

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Remarks:

____

____

PATIENT HISTORY & INFORMATION

Date: ______________________

Birth Date: ______________________

NAME DR. / MR. / MRS. / MISS: ______________________ Age: ______ Sex: ______ Marital Status: ______

LAST FIRST MIDDLE

ADDRESS (Home): ______________________ Phone: ______________________

STREET CITY STATE/ZIP

Cell Phone: ______________________

EMAIL: ______________________ Work Phone: ______________________

Employer: ______________ Occupation: ______________ Social Security No.: ______________

Nearest Relative: ______________ Address: ______________ Phone: ______________

Who Referred you to us: ______________________

PERSON RESPONSIBLE FOR PAYMENT–

Name: ______________ Relationship: ______________ Phone: ______________

Address: ______________ City/State/zip: ______________

Employer: ______________ Occupation: ______________ Social Security No.: ______________

Birth Date: ______________

Insurance company: ______________ Policy No.: ______________

In whose name is policy carried: ______________ Insurance eligibility dates: ______________

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable for the care of the patient named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending dentist, his dental assistant or qualified designate.

I unconditionally agree to be responsible for and to pay B. R. Bendush, D.D.S. P.C., for any and all of his charges which are not covered by insurance. I agree and understand that in the event I do not pay the amount or amounts due B. R. Bendush, D.D.S. P.C., and my account is placed in the hands of an attorney for collection proceedings, I will be legally responsible for all attorney fees, court costs, collection costs, consideration for assignment, litigation expenses, as well as any other incidental expenses incurred by B. R. Bendush, D.D.S. P.C., and/or his assignee(s). I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days.

Signed ______________________

Patient, Parent or Agent (must be 18 Years or older