

PATIENT HISTORY

GENERAL INFORMATION:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ APT # City: \_\_\_\_\_ Zip: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Home Phone :( ) \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_  
 E-mail: \_\_\_\_\_

MEDICAL HISTORY:

Have you ever had any of the following medical conditions? (Check "yes" no".)

CONDITION	YES	NO	DATE	CONDITION	YES	NO	DATE	CONDITION	YES	NO	DATE
Rheumatic Fever				Diabetes				Special Diets			
Heart Trouble/Pacemaker				Kidney Trouble				Psychiatric Problems			
High Blood Pressure				Urinary Problems				Arthritis			
Chest Pain				Cancer/Tumors				Frequent Headaches/Tension			
Shortness of Breath				radiation Treatment				Major Operations			
Lung Disease				Hepatitis				Intestinal Problems			
TB or Emphysema				Liver Disease				WOMEN:			
Allergies				Venereal Disease				Are you pregnant?			
Sinus				Stomach Ulcers				Menstrual Problems?			
Asthma/Hay Fever				Anemia				R3R DOCTORS USE:			
Epilepsy/Seizures				Clotting Problems				Blood Pressure			
Fainting Spells				Excessive Bleeding				Pulse			

Have you been tested for the HIV (AIDS) Virus? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, results: Positive, \_\_\_\_\_ Negative \_\_\_\_\_  
 Weight: \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_

Are you under the care of a physician now? \_\_\_\_\_ For what reason \_\_\_\_\_

Are you receiving any medication? \_\_\_\_\_ What? \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_ To what? \_\_\_\_\_

Are you allergic to or have adverse reaction to Novocain? \_\_\_\_\_

DENTAL HISTORY:

Are you having problems with your teeth/mouth? \_\_\_\_\_ What problems? \_\_\_\_\_

Date and purpose of last dental exam \_\_\_\_\_ Previous Dentist \_\_\_\_\_

Have you had gum or periodontal treatment \_\_\_\_\_ .Have you ever had orthodontics (braces)? \_\_\_\_\_

Are you pleased with the appearance of your teeth? \_\_\_\_\_ If not, why? \_\_\_\_\_

PERSONAL INFORMATION:

Patient employed by \_\_\_\_\_ Spouse employed by \_\_\_\_\_

Business address \_\_\_\_\_ Business address \_\_\_\_\_

Occupation \_\_\_\_\_ Occupation \_\_\_\_\_

In case for emergency, notify: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

How did you hear about this office? \_\_\_\_\_

Wife (Mom)	Social Security Number:	
Husband (Dad)	Social Security Number:	
Children: (1)	Age: (3)	Ad8:
(2)	Age: (4)	Age:
Your nearest relative (not living with you):	Phone: ( )	
Next closest relative (not living with you):	Phone: ( )	

*CONSENT FOR DENTAL TREATMENT:*

I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics or x-rays as may be deemed necessary by the Doctor.

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

*FINANCE POLICY:*

It is our office finance policy that our patients pay for their services at the time they are rendered or in advance, if you wish. We do accept dental insurance; however, the full debt for services is the patient's responsibility. At times financial arrangements may be needed. I hereby authorize this dental office to secure information which will help in the determination of financial arrangements. Our primary concern is that you complete your dental treatment plan so you can have the optimum dental health without financial stress.

Signature of person responsible for payment: \_\_\_\_\_

Please check: Cash \_\_\_ Master Card \_\_\_ Visa \_\_\_ Other \_\_\_ Insured with \_\_\_\_\_

*MEDICAL UPDATE:*

Changes in health: _____	<b>Date:</b> _____
_____	Date: _____
_____	Date: _____
_____	Date: _____

*ADDITIONAL INFORMATION/REMARKS:*

## CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)\_\_\_\_\_ 's dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for all payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

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

Patient/Responsible Party's  
Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

# FRIENDLY, GENTLE DENTISTRY

**JOEL R. BENK, DDS**

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## ASSIGNMENT OF BENEFITS FORM

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

Address: \_\_\_\_\_  
\_\_\_\_\_

I hereby authorize release of any medical information to any insurance carrier or attorney concerning my treatment and physical condition in order to process any claim for reimbursement of charges incurred at this office by me.

I hereby authorize you to pay directly to Dr. Benk benefits due me out of indemnity under the terms of my policy issued by your company.

Payment is authorized upon your receipt of the Doctor's itemized statement for services rendered to me. This policy was in full force and effect at the time services were rendered. Payment of this amount as herein directed, in whole or part, shall be considered the same as if paid by your company directly to me. You are directed not to mail payment for treatment by Dr. Benk to anyone other than Dr. Benk.

I hereby assign, and transfer to you, the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to your office for the charges incurred. In the event any such company refused payment, you are authorized to prosecute said action either in my name or your name as you see fit and compromise, settle or otherwise resolve said claim as you see fit.

I understand I personally owe any amount, in whole or in part, for which the insurance carrier does not reimburse your office.

Signed: \_\_\_\_\_

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

# FRIENDLY, GENTLE DENTISTRY

## JOEL R. BENK, DDS

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### OUR POLICY REGARDING DENTAL INSURANCE

Our Policy Regarding Dental Insurance:

Whether you have purchased dental insurance on your own or your employer has provided it for you, you are fortunate to have it and we will go the extra mile to help you maximize your benefits provided by your specific plan. If you wish, we will also be glad to help you file your insurance forms, which will save you considerable time and trouble. Your insurance company will reimburse you for the expenses they agree to pay. The insurance company usually only pays a percentage of the fee, and this varies from plan to plan. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. A better term for dental insurance may be "dental assistance".

*Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between us and the insurance company.*

On rare occasions, a dental insurance plan will require a "predetermination" or "prior authorization" for treatment, though most insurance companies do not require this. If they do, we will be happy to submit a treatment plan to your insurance carrier on request.

In order for us to submit your form, we ask that you provide the following:

1. A copy of your insurance booklet or a copy of your insurance card.
2. A copy of a signed insurance form with the insured's birth date, social security number, group or ID number, and the name of employee, whichever is applicable.

I have read and understood the above.

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

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

### OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered your responsibility. The following is a statement of our financial Policy, which we require that you read, agree to and sign prior to any treatment

All patients must complete our Patient Information Form before seeing the doctor.

#### **FULL PAYMENT IS DUE AT TIME OF SERVICE.**

**RETURN CHECK will be sent to a National Collection Service to be presented electronically for collections and will assess a return check fee against your account.**

How will you be taking care of your account? \_\_\_\_\_ cash \_\_\_\_\_ check \_\_\_\_\_ credit card

We accept Visa, MasterCard, American Express & Discover.

A credit report may be obtained. In the event payments are not received by agreed upon dates, I understand that a 1 1/2 service charge (18% APR) may be added to my account. If collection procedures are instituted because of failure to pay, I agree to pay all court costs and collection fees, including reasonable attorney's fees, to the extent permitted by applicable law.

### REGARDING INSURANCE

Dental insurance is great! We will gladly help fill out all those complicated forms for you and even accept the assignment of insurance benefits so that your "out of pocket" can be minimized. We will even allow our office insurance "expert" to evaluate your particular insurance plan and work to get you the maximum reimbursement—all just for you! (Please bring all your Insurance information or insurance booklet with you to help us out) We cannot bill your insurance unless you bring all insurance information. Should you have any change in your insurance information please inform the practice before your appointment or any services rendered. You should remember that your insurance policy is a contract between you and your insurance company and we are not a party to that contract. What that means is our doctors work for and get paid by you. i.e., you are ultimately responsible for the payment of all fees for our service.

**Concerning Insurance Co-Payments:** You will need to pay any deductible and fee co-payments the day of your appointment with cash, check, or Credit Card. If your insurance company has denied or not paid your account in full in 75 days, the balance of your account will then become your responsibility to pay within 15 days. Please be aware some and perhaps all of the services provided may be "non-covered" service and not considered so-called reasonable and necessary under you insurance program.

Regardless of the insurance company's determination of usual and customary rates or amount of assignment, you are required to pay the full amount charged by our office. There are no write off of fees.

### ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

### MINORS

The adult accompanying a minor and the parents or guardians is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a credit card or payment by cash or check at the time of service.

### MISSED APPOINTMENTS

Unless you have cancelled at least 48 hours **in advance** our policy is to charge \$39.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

**I have read, understand and accept this Company's Financial Policy as stated here.**

Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_