PATIENT INFORMATION: **TODAY'S DATE:**_____

NAME: _____
FIRST **LAST** **MIDDLE**

ADDRESS: _____
STREET **CITY** **STATE** **ZIP**

HOME PHONE: _____ **CELL PHONE:** _____

WORK PHONE: _____ **EMAIL:** _____
(WE WILL NOT SHARE YOUR EMAIL)

Marital Status: _____ **Single** _____ **Married** _____ **Separated** _____ **Divorced** _____ **Widowed**

Birthdate: _____ **SSN:** _____ **SEX:** ____ **Male** ____ **Female**

ACCOUNT INFORMATION:

Who is responsible for paying this account? _____

Relationship to the patient: _____ **Self** _____ **Spouse** _____ **Parent** _____ **Other:** _____

Responsible Party/Parent/Spouse		**Responsible Party/Parent/Spouse**	
Name:	_____	**Name:**	_____
Address:	_____	**Address:**	_____
Phone:	_____	**Phone:**	_____
DOB:	_____	**DOB:**	_____
SSN:	_____	**SSN:**	_____

List other patients included on this account: _____

Responsible Party's Employer: _____

Do you own your own business? ____ **N** _____ **Y** **Business Name:** _____

Type of Business/Service or Merchandise: _____

INSURANCE INFORMATION: *We file all primary insurance as a courtesy to our patients. It is your responsibility to verify coverage with your insurance company.*

Does the patient have dental insurance? _____ **Y** _____ **N** **Policy Holder:** _____

Relationship to the patient: _____ **Self** _____ **Spouse** _____ **Child** _____ **Other:** _____

POLICY HOLDER INFORMATION: **Member ID:** _____ **Group ID:** _____

Employer: _____

Business Address: _____

Insurance Company: _____

DENTAL INFORMATION:

What pharmacy do you use? _____

Previous Dentist: _____ Date of Last Dental Exam: _____

How do you feel about your smile? _____

What, if anything, would you change about your smile? _____

_____

How often do you brush your teeth? _____ How often do you floss? _____

What type of toothbrush do you use? ☐ Hard ☐ Medium ☐ Soft

Yes	No	
☐	☐	Do your gums bleed when you brush?
☐	☐	Have you ever been diagnosed as having periodontal disease (gum)?
☐	☐	Do you get frequent blisters on your lips or in your mouth?
☐	☐	Do you have any discomfort in your mouth presently? Specify _____
☐	☐	Are your teeth sensitive to heat, cold, sweets, pressure? (circle one)
☐	☐	Are you aware of any oral habits such as thumb sucking, nail biting, mouth breathing? (circle one)
☐	☐	Have you ever had your teeth straightened?
☐	☐	Have you ever experienced a problem with local anesthesia?
☐	☐	Do you have pain/clicking when opening or closing your jaw?
☐	☐	Have you ever had TMJ treatment?
☐	☐	Do you have any removable appliances such as a partial or denture?
☐	☐	Are you aware of grinding or clenching your teeth?
☐	☐	Are you aware of any swelling or lump in your mouth? Specify _____

REFERRAL INFORMATION:

Whom may we thank for referring you to our office? _____

EMERGENCY CONTACT:

Name: _____ Phone: _____

MEDICAL CONTACT:

Physician: _____ Phone: _____

The information I have provided is correct to the best of my knowledge and I agree to inform Bennett Family Dentistry of any or dental changes.

Signature: _____ Date: _____

BENNETT FAMILY DENTISTRY

1200 N Cape Rock Dr
Cape Girardeau MO 63701
573-334-8013 www.bennettdentistry.com

CONSENT FOR CARE
ASSIGNMENT OF BENEFITS
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, the undersigned, consent to the use and disclosure of my protected health information by Bennett Family Dentistry for the purposes of carrying out my treatment, for obtaining payment for my dental care, or for carrying out the health care operations of Bennett Family Dentistry.

I understand that I have a right to review Bennett Family Dentistry's Notice of Privacy Practices prior to signing this document. I hereby acknowledge that I received a copy of Bennett Family Dentistry's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Bennett Family Dentistry may use and disclose protected health information about me. A copy of this Notice of Privacy Practices is also provided in the waiting area of Bennett Family Dentistry.

Bennett Family Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I acknowledge that I have the right to request that the use of my protected health information be restricted in carrying out my treatment, obtaining payment for my dental care, or for carrying out the health care operations. However, I understand that Bennett Family Dentistry is not obligated to agree to any such restriction. If Bennett Family Dentistry and I agree upon any restrictions, such restrictions will be in writing and both Bennett Family Dentistry and I will agree to terminate any such restriction in writing.

My "protected health information" includes all individually identifiable information which is created or received by Bennett Family Dentistry and which relates to my past, present, or future physical or mental health or condition; to the provision of health and/or dental care to me; or to the past, present, or future payment for the provision of health and/or dental care to me.

I hereby assign all medical and/or third party payer benefits to which I am entitled, including private insurance and/or any other health plan to Bennett Family Dentistry for any services furnished me by Bennett Family Dentistry. I authorize Bennett Family Dentistry to release any protected health information to such insurance, to the extent such information is needed to determine benefits or benefits payable for related services. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that payment is expected at the time of service. If the above services are being provided to a minor, the personal representative below agrees that he/she is financially responsible for all charges whether or not paid by said insurance.

A photocopy, fax copy, or digital/scanned copy of this Consent, Assignment of Benefits, and Acknowledgement of Receipt of Privacy Notice is to be considered as valid as the original.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Description of Personal Representative's Authority

I, _____, give Bennett Family Dentistry, permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payment for dental services I receive from Bennett Family Dentistry. This consent is valid until such time as I provide Bennett Family Dentistry written revocation of it.

Bennett Family Dentistry may speak with:

Name:_____ Name:_____
Relationship:_____ Relationship:_____