BENASSI FAMILY DENTISTRY

PATIENT INFORMATION Whom may we thank for referring you? _____

Patient Name _____ _____ _____
Last Name First Name Middle Initial

Sex □ M □ F Age_____ Date of Birth ____/____/____ Social Security No. _____/_____/_____

□ Married □ Single □ Divorced □ Minor Driver License No._____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone-Ext. (____) _____

E-mail Address _____ Best time and place to reach you _____

Occupation _____ Patient Employer/School _____

Employer/School Address _____ Employer/School Phone (____) _____

Spouse/Guardian Name _____ _____ _____
Last Name First Name Middle Initial

Sex □ M □ F Age_____ Date of Birth ____/____/____ Social Security No. _____/_____/_____

Address (if different) _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone-Ext. (____) _____

Spouse/Guardian Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

DENTAL INSURANCE INFORMATION

Who is responsible for this account? _____ Relationship to Patient _____

Insurance Company _____ Group No. _____ Insurance Phone No. (____) _____

Subscriber's Name _____ Place of Employment _____

Additional insurance? □ Yes □ No Relationship to Patient _____

Secondary Insurance Company _____ Group No. _____ Insurance Phone No. (____) _____

Subscriber's Name _____ Birth Date ____/____/____ Social Security No. ____/____/____

IN CASE OF EMERGENCY, CONTACT: Name _____ Phone No's (____) _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents(s), have insurance coverage with _____
Name of Insurance Company (ies)

And assign directly to Dr. Benassi all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ ____/____/_____
Signature of Patient, Parent, Guardian or Personal Representative Date

ANTHONY F. BENASSI, DDS

HEALTH HISTORY

PATIENT NAME_____

MEDICAL ALERT_____

1. Are you in good health? **Y N**
2. Has there been any change in your health within the past year? **Y N**
3. Date of last physical exam?_____
4. Are you now under medical care? **Y N**
   If so, for what? _____
5. Have you ever had a serious illness or operation? **Y N**
   If so, explain_____
6. Do you smoke? **Y N**
7. Do you have fluoride in your water? **Y N**
8. Do you have or have you ever had any of the following?
   - Rheumatic fever or rheumatic heart diseases **Y N**
   - Congenital heart disease **Y N**
   - Cardiovascular disease (endocarditic, heart murmur, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) **Y N**
   - Allergy or hay fever **Y N**
   - Asthmas **Y N**
   - Hives or skin rash **Y N**
   - Fainting spells **Y N**
   - Diabetes **Y N**
   - Hepatitis, jaundice or liver disease **Y N**
   - Arthritis (rheumatoid or osteo) **Y N**
   - Ulcers (stomach or intestinal) **Y N**
   - Kidney trouble (nephritis, etc.) **Y N**
   - Tuberculosis **Y N**
   - Persistent cough or cough up blood **Y N**
   - Venereal disease (syphilis, gonorrhea, other) **Y N**
   - Epilepsy or seizure disorder **Y N**
   - Artificial joint prosthesis **Y N**
   - Substance abuse (alcoholism or drug addition, active or recovering) Immune system depression (organ transplant, AIDS, HIV, cancer chemotherapy) **Y N**
9. Do you have pain in chest upon exertion? **Y N**
10. Are you ever short of breath after mild exercise? **Y N**
11. Do your ankles swell? **Y N**
12. Do you get short of breath when you lie down, or do you require extra pillows to sleep? **Y N**
13. Have you had abnormal bleeding associated with previous surgery, extractions, or accidents? **Y N**
14. Have you ever required a blood transfusion? **Y N**
15. Do you have any blood or bleeding disorder (anemia, abnormal platelet function, etc.) **Y N**
16. Have you ever had surgery or x-ray treatment for a tumor, growth, or other condition? **Y N**
17. Are you taking any of the following?
   - Antibiotics or antiviral medicine **Y N**
   - Anticoagulants (Blood thinner) **Y N**
   - Medicine of high blood pressure **Y N**
   - Cortisone or steroids **Y N**
   - Nervous system medicine (antidepressants, antipsychotics, anti-anxiety) **Y N**
   - Asthma or respiratory medicines **Y N**
   - Aspirin or anti-inflammatory agent **Y N**
   - Dilantin or other seizure medicine **Y N**
   - Antidiabetic medicine (Insulin, Micronase, etc.) **Y N**
   - Digoxin or drugs for heart trouble **Y N**
   - Nitroglycerin **Y N**
   - Narcotic Analgesic **Y N**
   - Birth Control "pill" **Y N**
   - Recreational drugs or substances **Y N**
   - Any other? (prescription or over the counter) **Y N**

   _____
18. Are you allergic to or have ever reacted adversely to any of the following?
   - Local anesthetics (Novacaine, etc.) **Y N**
   - Penicillin or other antibiotics Y **N**
   - Aspirin or anti-inflammatory drugs **Y N**
   - Barbiturates, sedatives, or sleeping pill **Y N**
   - Narcotic analgesics **Y N**
   - Anti-anxiety or muscle relaxant medicine **Y N**
   - Any other_____ **Y N**
19. Have you had any serious trouble associated with any previous dental treatment? **Y N**
20. Do you have any disease, condition or problem not listed? **Y N**
    If so, please explain_____
21. Date of last dental exam_____
22. Have you ever been treated for any gum diseases (gingivitis, periodontitis, trenchmouth, pyorrhea)? **Y N**
23. Do your gums bleed when you brush your teeth? **Y N**
24. Do you grind or clench your teeth? **Y N**
25. Have you often had toothaches? **Y N**
26. Have you had frequent sores in your mouth? **Y N**
27. Have you had any injuries to your mouth or jaws? **Y N**
    If so, please explain_____
28. Do you have any sores or swelling of your mouth or jaw? **Y N**
28. Have you been satisfied with your previous dental care? **Y N**

WOMEN

29. Are you pregnant? **Y N**
    If so, how many months_____

ANTHONY F. BENASSI, DDS

MEDICAL HISTORY UPDATE

PATIENT NAME	PREFERED NAME
MEDICAL ALERT	D.O.B.

DATE: ____________

HEALTH CHANGES: ____________________

PHYSICIAN'S NAME ____________________

PHYSICIAN'S PHONE ____________________

CURRENT MEDICATIONS

1. ____________________
2. ____________________
3. ____________________
4. ____________________

LAST PHYSICAL EXAM ____________

ALLERGIES? ____________________

PATIENT SIGNATURE: ______________________________ STAFF INITIALS ______

DATE: ____________

HEALTH CHANGES: ____________________

PHYSICIAN'S NAME ____________________

PHYSICIAN'S PHONE ____________________

CURRENT MEDICATIONS

1. ____________________
2. ____________________
3. ____________________
4. ____________________

LAST PHYSICAL EXAM ____________

ALLERGIES? ____________________

PATIENT SIGNATURE: ______________________________ STAFF INITIALS ______

DATE: ____________

HEALTH CHANGES: ____________________

PHYSICIAN'S NAME ____________________

PHYSICIAN'S PHONE ____________________

CURRENT MEDICATIONS

1. ____________________
2. ____________________
3. ____________________
4. ____________________

LAST PHYSICAL EXAM ____________

ALLERGIES? ____________________

PATIENT SIGNATURE: ______________________________ STAFF INITIALS ______

DATE: ____________

HEALTH CHANGES: ____________________

PHYSICIAN'S NAME ____________________

PHYSICIAN'S PHONE ____________________

CURRENT MEDICATIONS

1. ____________________
2. ____________________
3. ____________________
4. ____________________

LAST PHYSICAL EXAM ____________

ALLERGIES? ____________________

PATIENT SIGNATURE: ______________________________ STAFF INITIALS ______