Patient Health Record/Update

Name_____ Date _____

Age_____ Date of Birth _____ SS# _____

Home Address _____ City/Zip_____

Home Phone _____ Mobile Phone _____ Work Phone_____

May we leave a voice message? Yes ☐ No ☐ Text? Yes ☐ No ☐

Emergency Contact Name _____ Phone Number _____

Insurance Co _____ Name of Insured _____

ID# _____ Gp# _____ DOB Insured _____

How did you find us? Internet ☐ Website ☐ Patient ☐ _____ Other ☐ _____

Date of Last Physical Exam _____ Name of Physician _____

Pharmacy Name/Number _____

Have you been hospitalized or under Physician's Care in the past 2 years? Yes ☐ No ☐

If yes, please explain _____

Any major surgeries? Yes ☐ No☐ If yes, please explain _____

Do you require antibiotics prior to dental work? Yes ☐ No ☐ Pre-Med Yes ☐ No ☐

Pregnant or Nursing? Yes ☐ No ☐ Do you take birth control? Yes ☐ No ☐

Do you take osteoporosis meds, Fosamax, Boniva or other bisphosphonates? Yes ☐ No ☐

Allergic to: Latex ☐ Local Anesthetics ☐ Penicillin ☐ Aspirin ☐ NSAIDS ☐ Codeine ☐ Other ☐

Please list **ALL** medications *and* supplements:

_____

test _____

Have you had, or do you now have:

High Cholesterol	☐	Artificial Heart Valves	☐	Epilepsy/Seizures	☐
High blood pressure	☐	Artificial Joints	☐	Fainting	☐
Atrial Fibrillation	☐	Asthma	☐	Heart Attack/Date	☐
ADD/ADHD	☐	Cancer/ Type_____	☐	Hepatitis	☐
AIDS/HIV Positive	☐	Chemotherapy	☐	Herpes	☐
Allergies	☐	Compromised Immunity	☐	Kidney Disease	☐
Anemia	☐	Congenital Heart Defect	☐	Liver Disease	☐
Angina/Chest Pain	☐	Diabetes	☐	Organ Transplant	☐
Heart Valves	☐	Psychiatric Care	☐	Smoke / Dip	☐
Thyroid Disease	☐	Tuberculosis	☐	Stomach Issues	☐
Pacemaker	☐	Prolonged Bleeding	☐	Stomach Ulcers	☐
Pneumonia	☐	Recreational Drug Use	☐	Cigarettes	☐
Radiation Therapy	☐	Severe Gag Reflex	☐	Sleep Apnea	☐

Other: _____

☐ I understand that withholding information could seriously jeopardize my safety, and I have answered truthfully to the best of my knowledge.

_____ _____

Signature Date

Financial Responsibility

Thank you for choosing Bender Dental Associates. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

Cash, Check, Visa, Mastercard, American Express and Discover

Monthly Financing Options Available

- NO INTEREST Payment Plans from CareCredit and Cherry Financing
  Allows you to pay overtime, 6-12 months, with NO interest (subject to approval). No annual fees or pre-payment penalties.

For Patients with Dental Insurance

For patients with dental insurance: we are happy to work with your primary dental insurance carrier to maximize your dental benefit and directly bill them for reimbursement. Ultimately you are responsible for the services and treatment you receive**. We are a Non-Participating provider for all insurance**. Some insurance companies pay the patient directly, not us. This is a function of each specific plan your employer has chosen for you. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. **Please remember you are fully responsible for all charges by this office regardless of insurance coverage.** We will file ONE appeal on your behalf. If your insurance carrier has not paid the claim within 60 days, you are responsible for the entire balance and a $50 late fee will incur each month.

Bender Dental Associates charges $50 for returned checks.

$75 will be charged to your account for missed dental appointments without 48-hour notice. Cancellation and missed appointment fee's must be paid prior to rescheduling.

If you have any questions, please don't hesitate to ask. We are here to help you get the dentistry you want and need.

Patient, Parent or Guardian Signature: _____ Date:_____