Welcome ✧

Dr.s Bencivengo & Ko D.M.D

PATIENT INFORMATION

TODAY'S DATE _____

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____

Cell: _____ **Email:** _____ **Home phone:** _____

Social Security number: _____ If Patient is a Minor, give Parent's or Guardian's Name _____

EMPLOYER _____ Who May We Thank for Referring You to our Office? _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____ (LAST / FIRST / MIDDLE)

EMPLOYER _____ NO. OF YEARS EMPLOYED _____

OCCUPATION _____ SOC. SEC. # _____

WORK PHONE _____ BIRTHDATE _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY, STATE _____ PHONE _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

Do you require pre-medication? _____ **If yes, what do you pre-medicate with?** _____

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist:

City: State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain	#	LACK of concern	#
COST of treatment	#	MISSING work time	#

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Are you PREGNANT?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	AIDS/ARC/HIV Pos.	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Hepatitis C	Asthma
Rheumatic Fever	Liver Disease	Hay Fever
Congenital Heart Lesions	Blood Transfusion	Sinus Trouble
Mitral Valve Prolapse	Drug Addiction	Allergies or Hives
Artificial Heart Valve	Hemophilia (Bleeding Problems)	Diabetes
Heart Pacemaker	Fever Blisters	Thyroid Disease
Heart Surgery	Epilepsy or Seizures	Radiation Treatment
Artificial Joints (Hip, Knee)	Nervousness	Arthritis
Anemia	Psychiatric Treatment	Cortisone Medicine
Stroke	Glaucoma	Pain in Jaw Joints
Kidney Trouble	Chemotherapy (Cancer, Leukemia)	Alcoholism
Ulcers	Venereal Disease (Syphilis, Gonorrhea, etc.)	Cosmetic Surgery

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin	Latex (balloons, gloves, etc.)
Nitrous Oxide	Codeine	Penicillin	

Are you aware of being allergic to any other medications or substances? _____

If yes, please list: _____

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN _____ PHONE NO. _____

PATIENT Signature (Parent of Child) _____ Date: _____

✧ **Thank you for visiting our office today!** ✧