

**Benjamin Sun, D.D.S.**  
**Kathleen Bennett, D.D.S.**  
*General, Cosmetic & Implant Dentistry*

**WELCOME**

Welcome to our dental office. We are very excited to have you here as our patient. Our staff would like you to know that we are committed to providing you with the best care possible. Successful relationships are built on trust and communication. It is our goal to earn your trust and take care of your dental needs. If you ever have any questions regarding treatment, office policies, or anything else, please do not hesitate to ask any staff member or doctor.

In order to help us achieve these goals, we ask that you review the following office policies, and fill out and sign the following forms (patient information/consent form, health history). If you have any questions regarding these forms, please ask us.

**INITIAL VISIT:** Your first visit to our office will be with either Dr. Ben or Dr. Kathleen. They will do a comprehensive dental exam and take appropriate x-rays. From there, we can determine what treatment may or may not be needed.

**INSURANCE:** Our office is a Delta Dental Premier provider. We do not have a contractual arrangement with any other insurance company. However, we do want to help you receive the maximum reimbursement to which you are entitled to. As a convenience to you, we will help you process your insurance claims so that you can receive the maximum benefit.

**FINANCIAL POLICY:** We accept Visa, Mastercard and American Express. We deliver the finest care at the most reasonable cost to our patients. Therefore, payment is due at the time the service is rendered, unless other arrangements have been made in advance. As a courtesy, we will collect your estimated insurance portion from your carrier, but will ask you for your portion at the time of service. If you have any questions, please ask the front desk. *Please remember you are fully responsible for all fees charged by this office, regardless of your insurance coverage.*

**CANCELLATION POLICY:** We require at least **24 hours notice of cancellations** of scheduled appointments. Late notice or missed appointments may result in charges since that time was specifically allotted for you. Also, late patients may need to be rescheduled as we try to be on time for every patient scheduled. We do understand that on occasion, emergencies and illnesses are unavoidable. Please call us so that we can reschedule your appointment.

**RADIOGRAPHS (X-RAYS):** Our doctors choose carefully which and when x-rays are taken. X-rays allow us to see everything we cannot see with our own eyes. Without them we would not be able to provide dental treatment at the high level we are accustomed to. Our office utilizes digital x-rays which reduce your exposure significantly compared to traditional x-rays. If you have any concerns, please speak with one of the doctors.

I, THE UNDERSIGNED, HAVE READ AND AGREE WITH THE TERMS AND CONDITIONS LISTED ABOVE:

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PATIENT SIGNATURE

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DATE

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Chart# \_\_\_\_\_  
(For Office Use Only)

**Patient Information**

**Patient Name:** \_\_\_\_\_  
Last First MI (Preferred Name)

**Birth Date:** \_\_\_\_\_ **Gender:** \_\_\_\_\_ **Family Status:** \_\_\_\_\_

**Social Security #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **E-mail Address:** \_\_\_\_\_

**Phone Numbers: (Home)** \_\_\_\_\_ **(Cell)** \_\_\_\_\_  
**(Work)** \_\_\_\_\_ **(Ext/Other)** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street Apartment #  
\_\_\_\_\_  
City State Zip Code

**Referral Information:** \_\_\_\_\_  
*Whom may we thank for referring you to our practice?*

**Preferred Contact Method**

When confirming your dental appointments, I preferred to be contacted by (check 1 or more boxes):

- Home Phone**     **Cell Phone**     **Work Phone**     **E-mail**     **Text Message**

**Patient Consent**

The undersigned hereby authorizes the Doctor to take x-rays or use any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I understand that my dental insurance is a contract between the insurance carrier and the doctor. Therefore, I am responsible for all dental fees. If the family is not living together, the parent escorting a minor is responsible for all charges. Fees are due and payable at the time of service unless prior arrangements have been made. I assign all insurance benefits to the Doctor. A late charge will be added to any overdue balance and where appropriate, credit reports may be obtained. I understand that the information I have given is correct to the best of my knowledge; that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in medical status.

Patient's Signature (or Parent of child): \_\_\_\_\_ Date: \_\_\_\_\_

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

**HEALTH INFORMATION**

Have you ever had any of the following medical conditions, or procedures? Please check those that apply:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV positive          | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Osteoporosis / Osteopenia    |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Heart Conditions:        | <input type="checkbox"/> Psychiatric Care             |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Respiratory Treatment        |
| <input type="checkbox"/> Artificial Joints          | <input type="checkbox"/> Heart Attack(s)          | <input type="checkbox"/> Rheumatic Fever              |
| <input type="checkbox"/> Artificial Heart Valve     | <input type="checkbox"/> Irregular heart beat     | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Chest Pain/Angina        | <input type="checkbox"/> Shingles                     |
| <input type="checkbox"/> Bronchitis / Chronic cough | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Shortness of breath          |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Snoring / Sleep Apnea        |
| <input type="checkbox"/> Chemotherapy               | <input type="checkbox"/> High Cholesterol         | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Radiation Therapy          | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Swelling of feet/ankles      |
| <input type="checkbox"/> Chemical Dependency        | <input type="checkbox"/> Mitral valve prolapse    | <input type="checkbox"/> Thyroid disease              |
| <input type="checkbox"/> Circulatory Problems       | <input type="checkbox"/> Heart surgery            | <input type="checkbox"/> Tobacco habit:               |
| <input type="checkbox"/> Cortisone Treatments       | <input type="checkbox"/> Cardiac pacemaker        | <input type="checkbox"/> Smoking                      |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Herpes                   | <input type="checkbox"/> Smokeless                    |
| <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Epilepsy / Convulsions     | <input type="checkbox"/> Immune System problems   | <input type="checkbox"/> Tumors or Growths            |
| <input type="checkbox"/> Excessive Bleeding         | <input type="checkbox"/> Jaw Pain                 | <input type="checkbox"/> Ulcers                       |
| <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Other: _____                 |
| <input type="checkbox"/> Glaucoma / Eye disease     | <input type="checkbox"/> Liver Disease / Jaundice | <input type="checkbox"/> Other: _____                 |
| <input type="checkbox"/> Hay Fever / Sinus Problems | <input type="checkbox"/> Malignant Hyperthermia   |   |
|   | <input type="checkbox"/> Mental Health Problems   |   |

**MEDICATION & ALLERGIES**

Are you now taking or have you ever taken:

- |  |   |
|--|---|
| <input type="checkbox"/> Antidepressants                           | <input type="checkbox"/> Muscle relaxers                  |
| <input type="checkbox"/> Bisphosphonates (bone density medication) | <input type="checkbox"/> Nerve pills                      |
| <input type="checkbox"/> Blood Thinners (Coumadin, Aspirin, Advil) | <input type="checkbox"/> Pain killers (including aspirin) |
| <input type="checkbox"/> Diet Pills                                | <input type="checkbox"/> Stimulants                       |
| <input type="checkbox"/> Insulin                                   | <input type="checkbox"/> Tranquilizers                    |

Please list any other medication(s) you are taking (including over the counter, herbal or homeopathic products):

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Are you allergic to or have you ever had a reaction to:

- |   |   |
|---|---|
| <input type="checkbox"/> Penicillin                     | <input type="checkbox"/> Aspirin        |
| <input type="checkbox"/> Amoxicillin                    | <input type="checkbox"/> Valium         |
| <input type="checkbox"/> Sulfa Drugs                    | <input type="checkbox"/> Latex products |
| <input type="checkbox"/> Sulfites                       | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Codeine or other narcotics     | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Local Anesthetic (numbing med) | <input type="checkbox"/> Other: _____   |

**1-4 below for women only:** (women note: antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control)

- |  |   |
|--|---|
| 1. Is there a possibility of pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No                    |
| 2. Expected delivery date: _____   | 4. Are you taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Signature of patient, parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

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**Spouse or Responsible Party Information**

The following is for:  the patient's spouse     the person responsible for payment

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

Male    Female                       Married    Single    Child    Other: \_\_\_\_\_

Social Security #: \_\_\_\_\_                      Date of Birth: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_ (Work/Ext): \_\_\_\_\_

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

Street \_\_\_\_\_ Apartment # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Employment Information**

**PRIMARY**

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes    No

Last                      First                      MI

Insured's Birth Date: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

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

Patients' relationship to insured:  Self    Spouse    Child    Other: \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

\_\_\_\_\_

**SECONDARY**

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes    No

Last                      First                      MI

Insured's Birth Date: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

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

Patients' relationship to insured:  Self    Spouse    Child    Other: \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

\_\_\_\_\_