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. Xrays 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:

_____ _____

PATIENT SIGNATURE DATE

1240 S. Westlake Blvd. Suite 231
Westlake Village, CA 91361
t: (818) 597-9777 f: (818) 597-9595

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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:

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

MEDICATION & ALLERGIES

Are you now taking or have you ever taken:

- □ **Antidepressants**
- □ **Bisphosphonates (bone density medication)**
- □ **Blood Thinners (Coumadin, Aspirin, Advil)**
- □ **Diet Pills**
- □ **Insulin**
- □ **Muscle relaxers**
- □ **Nerve pills**
- □ **Pain killers (including aspirin)**
- □ **Stimulants**
- □ **Tranquilizers**

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

_____

_____

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

- □ **Penicillin**
- □ **Amoxicillin**
- □ **Sulfa Drugs**
- □ **Sulfites**
- □ **Codeine or other narcotics**
- □ **Local Anesthetic (numbing med)**
- □ **Aspirin**
- □ **Valium**
- □ **Latex products**
- □ **Other: _____**
- □ **Other: _____**
- □ **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? □ **Yes** □ **No**
2. Expected delivery date: _____
3. Are you nursing? □ **Yes** □ **No**
4. Are you taking birth control pills? □ **Yes** □ **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: _____

_____

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