

DR. JACK BEHN

WHO REFERRED YOU TO OUR OFFICE?

Date _____

Name _____ S.S. # _____ Birthdate _____

Address _____ Apt. # _____

City/State _____ Zip Code _____ E-mail Address _____

Home Phone # _____ Cell Phone # _____ Beeper # _____ Sex: M F Marital Status: M S D W

Driver's License # _____ State _____ Valid Thru _____

Spouse _____ Spouse's Place of Employment _____

Person responsible for account (if child, put parent's name) _____

Address (if different from above) _____

City/State/Zip Code _____

If Employed:

Name of Employer _____ Position _____

Address at Work _____ City/State _____ Zip _____ Work Phone # _____

Dental Insurance Only

#1 Insurance Company (Primary Carrier) _____ Ins. Co. Phone # _____

Name of Insured _____ DOB _____ S.S.# _____

#2 Insurance Company _____

Name of Insured _____ Relationship to Insurance Holder _____

Nearest Relative Not in the Same Household:

Name _____ Relationship _____

Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____

How will you pay for services rendered on this initial visit _____

Cash: _____ Check: _____ Credit Card # _____ Exp. Date _____



FINANCIAL POLICY

It is the policy of this office, after examination and diagnosis, to make an estimate of the dentistry to be performed. This will enable you as the patient to know exactly what work is planned and what your financial responsibility will be.

It is necessary to make definite financial arrangements before any major dentistry is stated. There are several possible methods of payment.

CURRENT PAYMENT: Payment in full at each appointment.

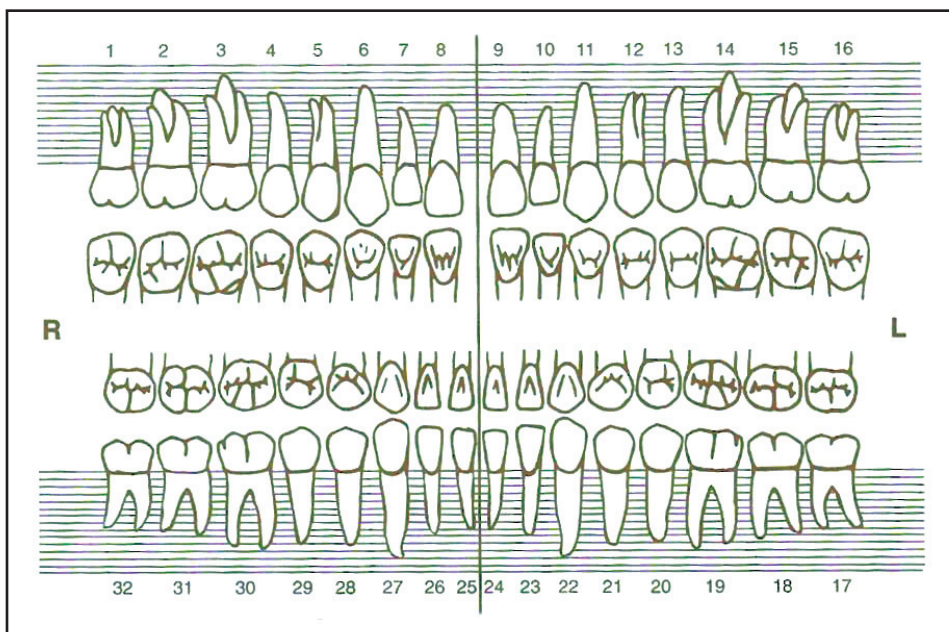
RESTORATIVE ARRANGEMENT: Fifty percent at preparation and the balance in full by date of cementation or delivery.

PROSTHETIC ARRANGEMENT: On-third at commencement of treatment, on-third at midway point and the balance at completion or delivery.

WE DO ACCEPT : VISA, MasterCard, American Express and Discover | We offer Care Credit - no money down and low monthly payments.

A firm understanding of financial involvement is essential for mutual benefit before beginning treatment in order to maintain a favorable environment and to assist you, the patient, to plan accordingly.

Out of respect for everyone's time we ask that you give us advance notice of 2 working days when changing an appointment, otherwise a nominal fee will be incurred.



OVERALL HEALTH AND WELLNESS QUESTIONNAIRE

Please rate your overall health

Excellent Good Fair Poor

Do you have a family history of heart attack or stroke? Yes No

Do you have a family history of periodontal disease? Yes No

When was the last time you had your blood pressure checked? _____

Date of your last complete physical exam and bloodwork _____

Do you have a family history of diabetes? Yes No

Do you have a family history of cancer? Yes No

Please share the following approximate dates

Your last cleaning _____

Your last complete set of x-rays _____

Your last oral cancer screening exam _____

If you could change your smile, would you:

(please check all that apply)

Make your teeth whiter

Make your teeth straighter

Close spaces between teeth

Replace black metal fillings with tooth-colored restorations

Repair chipped teeth

Replace missing teeth

Replace old crowns that don't match

Have a smile makeover

On a scale of 1 to 5 - (5 being the highest rating)

Please circle the numbers that best applies

How important is your dental health to you? 1 2 3 4 5

How would you rate your current dental health? 1 2 3 4 5

Where do you want your dental health care to be? 1 2 3 4 5

PATIENT MEDICAL HISTORY

Physician Name _____ Office phone number _____ Date of Last Exam _____

Are you under medical treatment now?YES NO
Are you taking any medication(s)
including non-prescription medicine?YES NO
If yes, what medication(s) are you taking? _____

Have you ever been hospitalized for any
surgical operation or serious illness within the last 5 years?YES NO
If yes, please explain _____

Have you ever taken Fosamax, Boniva, Actonel, or any cancer
medications containing bisphosphonates?YES NO
Do you use tobacco?YES NO
Do you use controlled substances?YES NO
Do you have a prosthetic or artificial hip or heart valve?YES NO

Are you allergic to or have you had any reactions to the following?
Local Anesthetics (e.g. Novocain)YES NO
Penicillin or any other Antibiotics.....YES NO
Sulfa Drugs.....YES NO
BarbituratesYES NO
SedativesYES NO
Iodine.....YES NO
AspirinYES NO
Any Metals (e.g. nickel, mercury, etc.).....YES NO
Latex Rubber.....YES NO
Other (please list) _____

Do you have a persistent cough or throat clearing not
associated with a known illness (lasting more than 3 weeks)?.....YES NO

Women Only:
a) Are you pregnant or think you may be pregnant?YES NO
b) Are you nursing?YES NO
c) Are you taking oral contraceptives?YES NO

DO YOU HAVE OR HAD ANY OF THE FOLLOWING?

Heart TroubleYES NO
Heart Attack.....YES NO
High Blood PressureYES NO
Heart DiseaseYES NO
Heart Murmur / Mitral Valve ProlapseYES NO
Stroke.....YES NO
Chest Pains.....YES NO
Easily Winded.....YES NO
Rheumatic FeverYES NO
Low Blood PressureYES NO
AnginaYES NO
Cardiac PacemakerYES NO
Diabetes.....YES NO

Liver DiseaseYES NO
Hepatitis / JaundiceYES NO
Respiratory Problems.....YES NO
EmphysemaYES NO
Swollen Ankles.....YES NO
AsthmaYES NO
AspirinYES NO
Fainting / Seizures.....YES NO
Epilepsy / Convulsions.....YES NO
Hay Fever / Allergies.....YES NO
TuberculosisYES NO
AnemiaYES NO
Frequently TiredYES NO

GlaucomaYES NO
Radiation TherapyYES NO
Cancer.....YES NO
Kidney DiseasesYES NO
Thyroid Problem.....YES NO
ArthritisYES NO
Recent Weight LossYES NO
Stomach Problems / Ulcers.....YES NO
AIDS or HIV Infection.....YES NO
Sexually Transmitted DiseaseYES NO
Joint Replacement or Implant.....YES NO
High Cholesterol.....YES NO
Other _____

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____ Date of Last Exam _____

Do your gums bleed while brushing or flossing?YES NO
Are your teeth sensitive to hot or cold liquids/foods?YES NO
Are your teeth sensitive to sweet or sour liquids/foods?YES NO
Do you feel pain to any of your teeth?YES NO
Do you have any sores, lumps or swelling in or near your mouth?YES NO
Have you had any head, neck or jaw injuries?YES NO
Have you ever experienced any of the following problems in your jaw?
ClickingYES NO
Pain (joint, ear, side of face)YES NO
Difficulty in opening or closingYES NO
Difficulty in chewingYES NO
Do you have an unpleasant taste or odor in your mouth?YES NO

Do you have frequent headaches?YES NO
Do you clench or grind your teeth?YES NO
Do you bite your lips or cheeks frequently?YES NO
Have you ever had any difficult extractions in the past?YES NO
Have you ever had any prolonged bleeding following extractions?YES NO
Have you had any orthodontic treatment?YES NO
Do you wear dentures or partials?YES NO
If yes, date of placement _____
Have you ever received oral hygiene instructions regarding
the care of your teeth and gums?YES NO
Do you like your smile?YES NO

Authorization and Release

I, the undersigned (patient) or legally responsible party, authorize dental treatment to be rendered by the dentist and his staff, and I assume all financial responsibility for treatment given, services rendered and all associated costs incurred as a result of my treatment. I have read, understand and agree that payment shall be made on time in accordance with the above terms and conditions. I agree to pay all costs of collection, court costs, attorney fees, billing cost, interest charges of 2% per month on the unpaid balance for accounts over 90 days and all other charges allowable under the law, incurred in the collection of amounts due, I acknowledge that all information contained herein is true and correct and give my permission to verify any of the information provided. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of any services rendered on my behalf or my dependants.

Photography, Video, Images and Testimonials

As part of your diagnosis and care we routinely record images of your smile and other conditions. Some of these images may be used for professional lectures, studies, training and promotion. Please allow us to use your image by agreeing to the following: for value received, I consent and authorize Dr. Jack W. Behn to use my image and/or testimonial letter, with or without my name, for dental health diagnosis, smile imaging, patient education, publication, research, promotion, professional lectures, or any other lawful purpose and I release and forever discharge him from any claim, demands or liability of such use for the quality of the image reproduction or text.

Date _____

Signature _____