Barry Henbest DDS

Patient Information

Patient Name: ______________________________ (Last / First / MI) Date: ______________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________ Birth Date: __________

Social Security #: ____________________ Driver's License # ________________ State ________

Phone (Home): ______________ (Work): ______________ Ext: ______ Best time to call: ____________

E-Mail: ____________________ Fax: ____________________ Mobil/Cell ____________________

Address: ____ (Street / Apartment #)

____ (City / State / Zip Code)

Health Information

Previous Dentist: ______________________________ Date of Last Dental Visit: ______________

Reason for this visit: ____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies ______________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Artificial Heart Valve
☐ Asthma
☐ Blood Disease
☐ Bruise Easily
☐ Cancer
☐ Cold Sores/Fever Blisters
☐ Contact Lenses
☐ Cortisone Medication
☐ Diabetes
☐ Diet (Special/Restricted)
☐ Dizziness
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ H. I. V. Positive
☐ Head Injuries
☐ Heart (Attack, Disease, Surgery)
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Latex Sensitivity
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Psychiatric/Psychological Care
☐ **Pregnancy**
Due date: ______________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Smoke/Chew Tobacco
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Allergic/Adverse Reaction To Medication or Any Substance, Please specify:
____
____
☐ Other: ______________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ____
  Phone: ________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you taking any medications? Please list ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

____ Date: ____________________

Signature of patient, parent or guardian

____ Date:

________________________ Signature of Doctor

Barry Henbest DDS

Cosmetic Information

Is there anything about your smile that you do not like?____

Are you interested in knowing the options available for a more beautiful smile?________________________

Do you like the appearance of your teeth?____

Are all of your teeth in alignment (straight)? ____

Do you have any missing teeth? ______________ Are any chipped? _________________________

Is your bite comfortable when chewing, biting? ____

Do you have frequent headaches? ____

Do you have any old fillings or dental treatment that you are unhappy with?_________________________

What would you like to change the most about the appearance of your teeth?________________________

____

Is there anything else that you would like us to know? ____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another Doctor ☐ Dental Office

☐ School ☐ Work ☐ Other________________

Name of person or office referring you to our practice:____

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 #: ____________________ Birth Date: _________ Driver's License #______________

Phone (Home): ______________ (Work): ______________ Ext:_____ Best time to call: ____________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________________ Occupation: ________________________

Address: ____

Street City State Zip Code

Barry Henbest DDS

Insurance Information

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #:_____________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other___________________

Insurance Plan Name and Telephone: ____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ___________ Relationship to Patient: ____________________
Signature of patient, parent or guardian

____ Date: ___________ Relationship to Patient: ____________________
Signature of guarantor of payment/responsible party