Benton Family Dental
149 Portsmouth Ave.
Stratham, NH 03885
(603) 772-3264

Patient Registration

First Name: _____Last Name: _____

Middle Initial:_____ Preferred Name:_____

Address: _____ Unit/Apt: _____

City: _____ State: _____ Zip: _____

Home Phone:_____ Cell Phone: _____

Gender: Male [ ] Female [ ] Date of Birth: _____

SSN(for insurance purposes): _____-_____-_____

Email Address: _____

Dental Insurance (if applicable)

Insurance Company: _____ Policy Holder: _____

Policy Holders Date of Birth: _____ Relationship to Policy Holder: Self [ ] Spouse [ ] Child [ ]

Employer/Group Name: _____Group Number: _____

Member/Subscriber ID#: _____

Dental Claims Address *(Typically on the BACK of your card):* _____

City: _____ State: _____ Zip: _____

Do you have a Secondary Insurance Plan? If so, please complete the following:

Insurance Company: _____ Policy Holder: _____

Policy Holder Date of Birth: _____ Relationship to P.H.: Self [ ] Spouse [ ] Child [ ]

Employer/Group Name: _____Group Number: _____

Member/Subscriber ID#: _____

Claims Address:_____ City: _____ State: _____ Zip: _____

MEDICAL HISTORY FORM

Please complete as accurately as possible.

Patient Name: _____ DOB: _____

Primary Care Physician: _____

1. Are you being treated by another physician for a medical condition (ex: diabetes, heart condition)? ☐ Yes ☐ No
If yes, who and for what? _____

2. Have you ever been hospitalized or had major surgery? ☐ Yes ☐ No
If yes: _____

3. Have you had a serious head or neck injury? ☐ Yes ☐ No *If yes:* _____

4. Are you currently taking medications, pills, or drugs? ☐ Yes ☐ No
If yes, list: _____

_____

5. Have you taken Fosamax, Boniva, Actonel, or other bisphosphonate medication? ☐ Yes ☐ No
If yes: _____

6. Do you have any heart conditions? ☐ Yes ☐ No

7. Do you take premedication before dental procedures? ☐ Yes ☐ No

8. Do you use tobacco? ☐ Yes ☐ No

Are you allergic to any of the following? :

Aspirin? YES [ ] NO [ ] **Metal?** YES [ ] NO [ ] **Penicillin?** YES [ ] NO [ ] **Latex?** YES [ ] NO [ ]
Codeine? YES [ ] NO [ ] **Sulfa Drugs?** YES [ ] NO [ ] **Acrylic?** YES [ ] NO [ ]
Local Anesthetics? YES [ ] NO [ ] **Other?** If yes _____

Women: Are you….

Pregnant? YES [ ] NO [ ] Nursing? YES [ ] NO [ ] Taking oral contraceptives? YES [ ] NO [ ]

Check the box for any conditions you have or have had:

☐AIDS/HIV Positive ☐Diabetes ☐Renal Dialysis ☐Asthma ☐Stroke ☐Venereal Disease ☐High Blood Pressure ☐High Cholesterol ☐Chest Pains ☐Cortisone Medicine ☐Ulcers ☐Frequent Cough ☐Stomach/Intestinal Issues ☐Anemia ☐Spina Bifida ☐Cold Sores/Fever Blisters ☐Low Blood Pressure ☐Chemotherapy ☐Cancer ☐Hepatitis A/B/C ☐Rheumatism ☐Artificial Heart Valve ☐Tuberculosis ☐Artificial Joint ☐Fainting/Dizzy Spells ☐Kidney Issues ☐Hives/Rash ☐Frequent Headaches ☐Jaw Joint Pain ☐Heart Disease/Disorder ☐Radiation Treatment ☐Easily Winded ☐Anaphylaxis ☐Arthritis/Gout ☐Excessive Bleeding ☐Excessive Thirst ☐Sinus/Breathing Trouble ☐Lung Disease ☐Tumors/Growths ☐Liver Disease/Jaundice ☐Osteoporosis ☐Psychiatric Care ☐Alzheimer's Disease ☐Drug Addiction ☐Epilepsy/Seizures ☐Emphysema/COPD ☐Heart Pacemaker ☐Hypoglycemia ☐Blood Disease ☐Blood Transfusion ☐Thyroid Disease

Other serious conditions not listed above? ☐ Yes ☐ No
If yes: _____

Signature: _____ Date: _____

Office Policies

Thank you for choosing our office for your dental needs! We appreciate your trust and look forward to working with you. In order to better serve you, we ask that all patients **read and sign** our office policies. If you have any questions, please ask.

1. INSURANCE: Your dental insurance benefits are a **contract between yourself, your employer, and your insurance carrier. We are not part of that contract.** Please notify us immediately if your insurance coverage changes. Not all dental services are covered under your dental policy. Each policy varies in exceptions, exclusions, waiting periods, and limitations. Your insurance is **your** responsibility; **you are responsible for knowing all guidelines, exclusions, waiting periods, and limitations**. Should you have any questions or need explanations about your insurance benefits, call your insurance. You are responsible for the balance if insurance benefits are denied.

2. FILING INSURANCE: As a courtesy to you, we will electronically file insurance claims and accept the assignment of benefits on your behalf.

3. PAYMENT: Payment is due at the time of services rendered (this includes yearly deductibles, copayments, and/or estimated out of pocket portions). If you have an outstanding balance following an insurance payment, you will be expected to pay the balance prior to additional treatment. We accept all major credit cards as well as cash or check. When using a credit card, a 3% surcharge will be applied to your total at checkout.

4. OVERDUE BALANCES: If your account balance exceeds 30 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 10 days of notification, your account will accrue a 5% interest charge for each month the balance is outstanding**. We reserve the right to cancel any future appointments that you may have with us if the balance is not paid within 30 days.** If your account exceeds 90 days past due, your account will be turned over to a collection agency. In this event, there is a collection fee (39% of the balance) that will be added to the balance.

5. RETURNED CHECKS: There will be a $30 fee for all returned checks. In the event of a returned check, your balance and fee must be paid via credit card or money order within 10 days of notification. If it is not paid, we will treat it as an overdue balance.

6. CHANGES IN PERSONAL INFORMATION: Please notify our office of any changes in your address, telephone numbers, or email address.

7. CANCELLATIONS/FAILED APPOINTMENTS: We reserve the right to charge a fee of $50.00 for any hygiene appointment and $100 for any doctor's visit missed or cancelled without **48-business hour notice.** If a conflict with your appointment time arises, please call us immediately.

8. INTERNET COMMUNICATIONS: We are a paperless office! By signing the office policies form below, I also grant my permission to the dental office to upload and store confidential information to the secured website of the dental practice. I also grant my permission to the dental practice to file my insurance claims electronically**. *I have read and understand the office policies of the practice and agree to the terms. ***

Patient Name: _____Signature: _____ Date: _____

(Or guardian if applicable)

Notice of Privacy Practices Patient Acknowledgement

As of December 1, 2015, Benton Family Dental has updated the Notice of Privacy Practices. I have read and understand the Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information. I can ask for a copy of the privacy practices at any time.

Patient Name: _____Signature: _____Date: _____

(Or guardian if applicable)

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Cancellation Policy

- A $50 deposit is required for all new patient appointments.
- 50% of your copay is required as a deposit when scheduling all basic restorative appointments.
- A $100 deposit is required for all crown (or major restorative) appointments.
- All deposits will be collected at the time of scheduling.
- Your deposit is fully refundable if your appointment is cancelled with at least 48-business hours' notice.

- For new patients:
  - If you decide to move forward with treatment, your deposit may be applied to future appointments.
  - If no treatment is diagnosed, we are happy to refund your deposit once all insurance claims are closed.

Patient Signature: _____ **Date:** _____

Consent Form

I give permission to Dr. Benton and his staff to discuss my care and any financial information with the following individual(s):

Name(s) and Phone Number(s):

_____

_____

_____

_____

_____

If you do not wish to authorize us to speak with anyone regarding your care or financials, please leave the line above blank.

Patient Signature: _____ **Date:** _____

Benton Family Dental
149 Portsmouth Ave.
Stratham, NH 03885
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Records Release to Our Office

Previous Dentist: _____

(Office/Dentist Name, address, and office phone number)

I hereby request that my and/or my family's dental records be released to:

Christopher Benton, D.M.D.
149 Portsmouth Ave. Stratham, NH 03885
T :(603)772-3264 ~ EMAIL: info@bentonfamilydental.com ~ F :(603)418-6316

Please send records for:

Patient Name:	Date of Birth:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient signature: _____
(or guardian if applicable)

Date: _____