

**Douglas G. Benting, DDS, MS, PLLC**  
*Practice Limited to Prosthodontics*

**Patient's Name** \_\_\_\_\_ Birthdate \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_ E-Mail \_\_\_\_\_

Employer \_\_\_\_\_ City \_\_\_\_\_ Occupation \_\_\_\_\_

Name of Parent /Partner/ Spouse / Guardian \_\_\_\_\_ Birthdate \_\_\_\_\_

(circle one) Social Security # \_\_\_\_\_

Address if different \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

Employer \_\_\_\_\_ City \_\_\_\_\_ Occupation \_\_\_\_\_

In case of emergency, whom shall we notify other than spouse?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION**

EMPLOYEE NAME \_\_\_\_\_

INS CO NAME \_\_\_\_\_

INS CO ADDRESS \_\_\_\_\_

INS CO CITY, ST, ZIP \_\_\_\_\_

INSURANCE PHONE \_\_\_\_\_

GROUP / POLICY # \_\_\_\_\_

EMPLOYEE SS # \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

**INSURANCE INFORMATION**

EMPLOYEE NAME \_\_\_\_\_

INS CO NAME \_\_\_\_\_

INS CO ADDRESS \_\_\_\_\_

INS CO CITY, ST, ZIP \_\_\_\_\_

INSURANCE PHONE \_\_\_\_\_

GROUP / POLICY # \_\_\_\_\_

EMPLOYEE SS # \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

**Patient Acknowledgments:**

- I understand that I am responsible for any uninsured balance.
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes.
- If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical practitioner/provider for any needed evaluation.

I have read the above: Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Guardian if a minor

**Douglas G. Benting, DDS, MS, PLLC**  
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PATIENT'S NAME		DATE OF BIRTH
PHYSICIAN'S NAME	PHYSICIAN'S ADDRESS	PHYSICIAN'S PHONE
DATE OF MOST RECENT VISIT TO PHYSICIAN		REASON

To ensure your well being while undergoing treatment in our office, please answer the following questions with a YES or NO response and provide further details for all YES responses. All information will be considered confidential and for our records only.

Are you currently seeing a physician for treatment of a recent or ongoing medical condition? If so, explain the condition.

\_\_\_\_\_

Have you been hospitalized within the last year? If yes, please explain:

\_\_\_\_\_

Have you ever had any serious medical trouble associated with any dental experience? If yes, please explain:

\_\_\_\_\_

Have you ever been advised to take antibiotics (like Penicillin, etc.) prior to a dental appointment? If yes, please explain:

\_\_\_\_\_

**Do you have OR have you had any of the following cardiovascular conditions? Answer Yes or No.**

- |  |   |
|--|---|
| <p><i>Yes / No</i> Heart Disease<br/><i>Yes / No</i> Heart Attack<br/><i>Yes / No</i> Coronary Bypass<br/><i>Yes / No</i> Angina<br/><i>Yes / No</i> Mitral Valve Prolapse<br/><i>Yes / No</i> Hardening of the Arteries<br/><i>Yes / No</i> High Blood Pressure<br/><i>Yes / No</i> Stroke<br/><i>Yes / No</i> Heart Murmur<br/><i>Yes / No</i> Shortness of Breath when lying down<br/><i>Yes / No</i> Chest Pain on Exertion<br/><i>Yes / No</i> Frequent or Unexpected Nose Bleeds</p> | <p><i>Yes / No</i> Rheumatic Fever or Rheumatic Heart Disease<br/><i>Yes / No</i> Congestive Heart Failure<br/><i>Yes / No</i> Congenital Heart Defects<br/><i>Yes / No</i> Prosthetic Heart Valves<br/><i>Yes / No</i> Pacemaker - Date of placement: _____ Type: _____<br/><i>Yes / No</i> Surgically Implanted Defibrillator<br/><i>Yes / No</i> History of Infective Endocarditis<br/><i>Yes / No</i> Heart Transplant<br/><i>Yes / No</i> Shortness of Breath after Mild Exercise<br/><i>Yes / No</i> Swelling of the Ankles<br/><i>Yes / No</i> Abnormal Bleeding or Extended Clotting Time</p> |
|--|---|

Do you consider yourself to be under an *abnormally* high amount of stress? \_\_\_\_\_

When was your last complete physical examination with your physician, including blood tests? \_\_\_\_\_

Do you OR have you ever smoked? \_\_\_\_\_ How much? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you use chewing tobacco? \_\_\_\_\_ How often? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_

**Do you have OR have you had any of the following health conditions? Please answer Yes or No.**

*Yes / No* Diabetes - Type: \_\_\_\_\_  
*Yes / No* Artificial Joints - Which joints? \_\_\_\_\_  
*Yes / No* Hepatitis - Which Type (A, B, or C)? \_\_\_\_\_  
*Yes / No* Blood Transfusion - When? \_\_\_\_\_  
*Yes / No* HIV  
*Yes / No* Tuberculosis  
*Yes / No* Alzheimer's Disease  
*Yes / No* Anemia  
*Yes / No* Asthma  
*Yes / No* Autoimmune Disease - Which One?  
*Yes / No* Blood Disorder  
*Yes / No* Cancer  
*Yes / No* Chemo Therapy  
*Yes / No* Chronic Sinus Problems  
*Yes / No* Cirrhosis  
*Yes / No* Depression

*Yes / No* Drug/Alcohol Treatment  
*Yes / No* Eating Disorder  
*Yes / No* Epilepsy/Seizures  
*Yes / No* Glaucoma  
*Yes / No* Herpes  
*Yes / No* Jaundice  
*Yes / No* Kidney Disease  
*Yes / No* Organ Transplant  
*Yes / No* Osteoporosis  
*Yes / No* Parkinson's Disease  
*Yes / No* Radiation Treatment  
*Yes / No* Severe Headaches  
*Yes / No* Sexually Transmitted Disease  
*Yes / No* Skin Conditions  
*Yes / No* Ulcers

**Are you ALLERGIC to ANY of the following:**

_____ Penicillin	_____ Nickel
_____ Sulfa	_____ Latex
_____ Local Dental Anesthetics	_____ Sulfites
_____ Codeine	_____ Barbiturates
_____ Sedatives	_____ Tranquilizers
_____ Aspirin	_____ Tetracycline

**WOMEN ONLY**

Are you pregnant? \_\_\_\_\_  
If so, expected delivery date? \_\_\_\_\_  
Do you have regular gynecological checkups? \_\_\_\_\_  
Have you reached menopause? \_\_\_\_\_  
Are you taking hormone replacement? \_\_\_\_\_  
Have you had a mammogram? \_\_\_\_\_ Date \_\_\_\_\_

Have you ever had an adverse reaction to **ANY** drug or medication? If yes, indicate medication and reaction:

Do you have **ANY** disease, condition or medical problem **Not Listed** on this form? If yes, please indicate the condition:

**Please indicate if you are currently taking ANY of the following listed medications OR if you have taken any of these medications within the past year.**

<i>Yes / No</i> Antibiotics	<i>Yes / No</i> Inhalants
<i>Yes / No</i> Antidepressants (Prozac, Zoloft, Etc.)	<i>Yes / No</i> Insulin
<i>Yes / No</i> Antihistamines	<i>Yes / No</i> Heart Medication/Nitroglycerine
<i>Yes / No</i> Blood Pressure Medication	<i>Yes / No</i> Muscle Relaxants
<i>Yes / No</i> Blood Thinners	<i>Yes / No</i> Pain Medication (Aspirin, Tylenol, Advil)
<i>Yes / No</i> Cortisone (Predisone)	<i>Yes / No</i> Sleeping Pills
<i>Yes / No</i> Cholesterol Medication	<i>Yes / No</i> Thyroid Medication
<i>Yes / No</i> Decongestants	<i>Yes / No</i> Tranquilizers
<i>Yes / No</i> Diuretics (water pills)	<i>Yes / No</i> Vitamins
<i>Yes / No</i> Hormones (birth control, estrogen)	

**Please list your current medications OR attach a list of your medications to this form:**

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*Patient signature*

*Date*

# Douglas G. Benting, D.D.S., M.S., PLLC

## Consent For Services

Since our practice depends upon reimbursement from our patients for the costs incurred in their dental care, financial responsibility on the part of each patient must be determined before treatment is rendered. As a condition of your treatment by this office, payment in full is required at the time services are performed unless a previous written financial agreement has been signed. Nonpayment, payment reversal or default of the terms agreed upon in a signed financial agreement will be assessed any bank fees, legal fees, collection costs or attorney fees incurred. Any items returned unpaid by your bank will be subject to a \$25 returned check fee. Any unpaid amounts remaining on your account shall after 30 days, be subject to finances charges calculated at the rate of 1.5% per month (18% APR).

Patients who carry dental insurance understand that all dental services rendered are charged directly to the patient and that he or she is personally responsible for payment of all dental services. As a service to the patient, this office will prepare and submit insurance claims and assist in obtaining proper reimbursement from your insurance carrier for completed services. However, this dental office cannot render services on the assumption that our charges will be paid by your insurance company. Any insurance amounts quoted are **NOT** a guarantee of payment, either by Dr. Benting, his staff or your insurance carrier, but are only intended to provide you with an **ESTIMATE** of benefits that might be available to you under your insurance plan benefits. All amounts not paid by your insurance carrier are ultimately your financial responsibility.

Patients must provide at least **3 BUSINESS DAYS** prior notice for all scheduling changes, in order to avoid a rescheduling fee of \$100.00 (one hundred dollars) per hour of scheduled appointment time.

***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

# **DOUGLAS G. BENTING, D.D.S., M.S., P.L.L.C.**

## **Consent for Use and Disclosure of Health Information**

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Name: \_\_\_\_\_ SS# \_\_\_\_\_

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

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

### **TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**Contact Person:** Karen or Dr. Benting **Address:** 301 E. Bethany Home Rd., Ste. C-172; Phoenix, AZ 85012  
**Telephone:** 602-277-9088 **Fax:** 602-277-8889 **E-Mail:** [drbenting@hotmail.com](mailto:drbenting@hotmail.com)

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

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### **Signature**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representatives Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**