BENSON DENTAL

Bruce A. Benson, DMD

Patient Information

Today's Date: _____

First Name: _____ M.I.: _____ Last Name: _____

Date Of Birth: _____ Social Security Number: _____ Marital Status: _____

Sex: _____ Email Address: _____

Home Ph #: _____ Cell Ph #: _____ Work Ph #: _____

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

Physician Name: _____ Physician Ph #: _____

Pharmacy: _____ Pharmacy Ph #: _____

Primary Dental Guarantor: _____

Home Ph #: _____ Cell Ph #: _____ Work Ph #: _____

Secondary Dental Guarantor: _____

Home Ph #: _____ Cell Ph #: _____ Work Ph #: _____

Patient Medical History

- Height: _____ Weight: _____
- Date of Last Visit: _____
- Date of Medical History: _____

WOMEN ONLY

Yes	No	
☐	☐	Are you taking birth control?
☐	☐	Are you pregnant? • If yes, # of weeks: _____
☐	☐	Are you nursing?

- Check boxes for any of the following that you have had in the past or have presently:

☐ Abnormal Bleeding	☐ Difficulty Breathing	☐ Hemophilia	☐ Shingles
☐ Alcohol Abuse	☐ Drug Abuse	☐ Hepatitis A/B	☐ Sickle Cell Disease
☐ Allergies	☐ Emphysema	☐ High/Low Blood Pressure	☐ Sinus Problems
☐ Anemia	☐ Epilepsy	☐ Joint Replacement	☐ Smoke or Use Tobacco
☐ Arthritis	☐ Fainting Spells	☐ Kidney Problems	☐ Stroke
☐ Artificial Heart Valve	☐ Fever Blisters	☐ Liver Disease	☐ Thyroid Problems
☐ Asthma	☐ Frequent Headaches	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Blood Transfusion	☐ Glaucoma	☐ Pacemaker	☐ Ulcers
☐ Cancer - Chemotherapy	☐ HIV+/AIDS	☐ Psychiatric Problems	☐ Venereal Disease
☐ Colitis	☐ Hay Fever	☐ Radiation Therapy	☐ Yellow Jaundice
☐ Congenital Heart Defect	☐ Heart Attack	☐ Rheumatic Fever	☐ Other
☐ Diabetes	☐ Heart Surgery	☐ Seizures	

- Is there any disease, condition, or problem not listed above that you think this office should know?..... ☐ Yes ☐ No

  If so, please explain: _____

  _____

- Notes: _____

  _____

  _____

FOR OFFICE USE ONLY ID: _____ BP: _____ Heart Rate: _____

MEDICAL ALERTS:

BENSON DENTAL

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Patient Medication Record

Full Name: _____

***Please list all medications you are currently taking** (include prescription, over-the-counter, and herbal)

☐ I am not currently taking any medications

Medication Name	Dosage	Reason for Taking

Patient Allergy Record

***Are you allergic to or have you had an adverse reaction to:** (check box and explain)

☐ I have no known allergies

☐ Aspirin
☐ Codeine
☐ Dental Anesthetic
☐ Other (List Below)

☐ Erythromycin
☐ Jewelry
☐ Latex

☐ Metals
☐ Penicillin
☐ Tetracycline

_____
_____
_____

Signature: _____ Date: _____

(Parent or Legal Guardian if Minor)