

HEALTH HISTORY FORM

Patient Information			
Patients Name Last _____ M I: _____ First _____		Sex: M F DOB: _____ Age: _____	
Address _____		City _____ State _____ Zip _____	
Marital Status: _____		Reason for this visit today _____ Today's date: _____	
If patient is a minor, please give Parent/Guardian's name: _____ How did you hear about our office _____			
Home Phone (_____) _____		Work Phone (_____) _____ Cell Phone (_____) _____	

Primary Dental Insurance Information	Secondary Dental Insurance Information
Insured's Name _____	Insured's Name _____
Insurance Co. _____	Insurance Co. _____
Insurance Co. Address _____	Insurance Co. Address _____
Insured's Employer _____	Insured's Employer _____
Insured's DOB: _____ Subscriber I.D # _____	Insured's DOB: _____ Subscriber I.D # _____
Group # _____ Local # _____	Group # _____ Local # _____
Insurance Phone #: _____	Insurance Phone #: _____

Dental History	Medical History
yes no	yes no
How long since your last dental visit? _____	Do you have any current health problems ? <input type="checkbox"/> <input type="checkbox"/>
Last complete dental exam? _____	Are you under a physician's care now? <input type="checkbox"/> <input type="checkbox"/>
Last time since you've had dental x-rays taken? _____	If yes, what? _____
Are you having any problems now? _____	What medications are you currently taking? _____
What? _____	_____
Is your present dental health poor ? <input type="checkbox"/> <input type="checkbox"/>	_____
Would you like to know more about permanent replacements ? <input type="checkbox"/> <input type="checkbox"/>	_____
Are you apprehensive about dental treatment? <input type="checkbox"/> <input type="checkbox"/>	_____
Have you had any periodontal (gum) treatment? <input type="checkbox"/> <input type="checkbox"/>	_____
Do your gums bleed , or feel tender or irritated ? <input type="checkbox"/> <input type="checkbox"/>	_____
Are your teeth sensitive to hot, cold, sweets, pressure? <i>circle all that apply</i>	_____
Are you unhappy with the appearance of your teeth? <input type="checkbox"/> <input type="checkbox"/>	_____
Are you aware of any grinding or clenching your teeth? <input type="checkbox"/> <input type="checkbox"/>	_____
Do you have headaches , earaches , or neck pains ? <input type="checkbox"/> <input type="checkbox"/>	Does your medical doctor require you to take an antibiotic/pre-med for dental appointments? <input type="checkbox"/> <input type="checkbox"/>
Have you worn braces on your teeth? (Orthodontics) <input type="checkbox"/> <input type="checkbox"/>	If yes, for what? _____
Do you have discolored teeth that bother you? <input type="checkbox"/> <input type="checkbox"/>	Do you smoke ? Use chewing tobacco ? <i>Circle all that apply</i> <input type="checkbox"/> <input type="checkbox"/>
Would you like your smile to look better or different ? <input type="checkbox"/> <input type="checkbox"/>	Are you pregnant ? <input type="checkbox"/> <input type="checkbox"/>
Do you regularly use dental floss ? <input type="checkbox"/> <input type="checkbox"/>	Are you Allergic to or have you ever reacted adversely to any of the following medications? <i>Circle all that apply</i>
Name of or your previous dentist: _____	Aspirin Amoxicillin Local Anesthetic Penicillin
City: _____	Latex Codeine Sulfa Erythromycin
State: _____ Phone #: (_____) _____	Other: _____
How do you feel about your teeth? _____	_____

Is there any other medical or dental information that we should be aware of?

If yes, what? _____ Family Physician _____ Phone # _____

Circle any of the following which you have had, or presently have

Acid Reflux	Asthma	Emphysema	High Cholesterol	Sleep Apnea
AIDS/A.R.C/HIV positive	Autism	Epilepsy / Seizures	Kidney Trouble	Stents/valve replacement
Alcoholism	Blood Transfusion	Fever Blisters	Liver Disease	Stroke
Allergies or Hives	Chemotherapy -cancer, etc	Heart Disease / Attack	Mitral Valve Prolapse	Thyroid Disease
Anemia	Congenital Heart Lesions	Heart Pacemaker	Osteoporosis	Tuberculosis (TB)
Angina Pectoris	Cosmetic Surgery	Hemophilia -bleeding issue	Pain in Jaw Joints	Ulcers
Arthritis	C.O.P.D	Hepatitis A (Infectious)	Psychiatric Treatment	Venereal Disease (syphilis..)
Artificial Heart Valve	Diabetes	Hepatitis B-serum or Hep C	Radiation Treatment	Vertigo
Artificial Joints (Hip, knee)	Drug Addiction	High Blood Pressure	Rhematic Fever	

CONSENT: The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy which may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understood that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor

PATIENT SIGNATURE _____ Date _____ Dentist signature _____

(if minor, then parent/guardian)

05-15-2013

Dental Associates of Lake Mills, Inc.

Dr. Jaclyn L. Benish D.D.S

Lake Mills Office:

311 E. Tyranena Park Rd.
Lake Mills, WI 53551-9681
Phone: (920) 648-2331
Fax: (920) 648-3437



Dr. Matthew J. Senn D.M.D

Marshall Office:

701 West Main St. Ste 155
Marshall, WI 53559-8982
Phone: (608) 655-1199
Fax: (608) 655-1144

www.lakemillsmiles.com

Patient Discounts Offered:

5% Payment Discount on estimated patient portion due on day of service

5% Senior Discount on estimated patient portion due on day of service (anyone 60 years or older)

PAYMENT AND BILLING POLICY

There will be a fee charged for dental services, additional procedures, and follow-up appointments where applicable. A treatment plan will be presented to you at the end of your appointment explaining your estimated out of pocket cost.

Does my dental insurance cover all your services? Dental insurance coverage varies widely. Not all policies cover the same type of services. It is your responsibility to understand what procedures are covered by your insurance.

We will make every attempt to contact your insurance carrier to verify eligibility and benefits. However, the eligibility and coverage information provided to us by your insurance carrier is subject to change during claims processing. Payment of claims is not guaranteed by our office or your insurance company at the time claim is processed. We will submit your claims for services on your behalf. By signing below, you authorize the insurance company to make the payment directly to Dental Associates of Lake Mills. **Any non-covered procedures including co-pays and deductibles will be your responsibility on the day of service.**

To ensure prompt processing of your claims, we need you to provide us with all dental insurance carrier information and any additional personal information required for filing your claim at the time of your initial visit. **Your insurance company and / or employer will not notify us of any changes, it is your responsibility to notify us of any changes, in your insurance status.**

What will I be expected to pay at the time of service if I do not have insurance? Payment in full is required at the day of service. We do offer several payment options.

How will I be billed? On the day of services, you will be asked to pay your estimated patient portion. We will as a courtesy submit your procedures to your insurance company. After insurance has cleared if a balance is still due a statement will be sent for the difference between the insurance company's payment (if not paid in full) and the charges for your procedures. This balance will be due upon receipt of the statement. Signing this document signifies that you have reviewed our payment and billing terms.

CANCELLATION POLICY

If you are unable to make an appointment you have scheduled with us, **please notify us at least 24 hours in advance or there is a \$30 charge without 24hr notice or missed appointments.**

Print Name: _____ Signature: _____ Date: _____
(if minor, then parent/guardian)