ARNOLD BENAK JR. DMD, LLC
317 FLANDERS ROAD
SUITES 204-205
EAST LYME, CT 06333
PHONE: 860-739-5700
FAX: 860-739-5279

Welcome

Thank you for choosing us to provide your dental care. We are a family oriented practice, offering a wide range of services for both children and adults. We want to help you achieve optimal dental health, comfort, function and appearance. We work in a friendly atmosphere that allows you to feel at home and relaxed.

Whether you are new to the area or new to our office, we would like to get to know you. Since your dental care can be affected by other health problems or allergies, we ask you to complete a health questionnaire and patient forms as completely and accurately as possible.

All visits are by appointment. This ensures that we able to spend enough time with each patient to get the best possible results. If you have to move your appointment, please give at least 24 hours notice unless its an emergency.

We appreciate you as a patient in our practice and we welcome any questions or concerns you may have about our services or office protocol. If you ware comfortable in out office please refer a friend or family and ask about our referral program. A referral is the best compliment.

Sincerely

Dr. Arnold Benak Jr. and Staff

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We believe in the importance of quality dental care, and we strive to provide the best dental treatment possible. We also understand the financial limitations that influence your choice of care and want to assure you of our flexible financing approach.

We work with most insurance companies and always try to maximize your coverage through meticulous detailing of procedures and interaction with your insurer. We will even fill out your claim forms

Please keep in mind that you are responsible for the portion of your treatment not covered by insurance. We do ask that you pay you portion of the bill at time of service. We will work with qualifying individual to devise a method of payment that works for both parties. We also accept most major credit cards.

Please rest assured that we are here to help make quality dental care obtainable for everyone. We look forward to working with you to achieve excellent dental health.

We are always available to answer any questions

Signature of acknowledgement and agreement

PRINT NAME:

SIGNATURE:

DATE:

CELL PHONE:

E-MAIL:

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YOUR APPOINTMENT IS RESERVED ESPECIALLY FOR YOU. SHOULD YOU NEED TO CANCEL OR RESCHEDULE, WE ASK FOR A COURTESY OF 24 HOURS NOTICE. THERE WILL BE A $55.00 CHARGE FOR ALL MISSED OR CANELLED APPOINTMENTS WITHOUT 24 HOUR NOTICE.

_____ DATE _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN

_____
PRINT NAME

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ HAVE RECEIVED A COPY OF THIS OFFICES NOTICE OF PRIVACY PRATICES. _____
RELATIONSHIP TO PATIENT

SIGNATURE _____ DATE_____

PRINT NAME_____

FOR OFFICE USE ONLY

-
WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES BUT, COULD NOT BE OBTAINED DUE TO:

☐ INDIVIDUAL REFUSED TO SIGN

☐ COMMUNIATION BARRIERS PROHIBITED OBTAINING ACKNOWLEDGEMENT

☐ AN EMERGENCEY SITUATION PREVENTED OBTAINTING ACKNOWLEDGMENT

☐ OTHER (PLEASE SPECIFY)

_____

_____

_____

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DENTAL HEALTH HISTORY

Reason for today's visit _____
Former dentist: _____
Dentist Address:_____
Date of last dental visit:_____ Date of last radiographs:_____

Check if you have had problems with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitive to hot
☐ Clicking or popping jaw	☐ Loose Teeth or Broken fillings	☐ Sensitive to sweets
☐ Bleeding Gums	☐ Periodontal treatment	☐ Sensitive when biting
☐ Sores or growths	☐ Food collection between Teeth	☐ Sensitive to cold
☐ Crowded Teeth	☐ Cracked Teeth	☐ Stained Teeth
☐ Missing Teeth		

How often do you brush per day?____ How often do you floss?_____

ARNOLD BENAK JR. DMD, LLC

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain:_____

Have you ever been hospitalized or had major surgery? ○ Yes ○ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain:_____

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain:_____

Do you take, or have you taken, Phen-fen or Redux? ○ Yes ○ No

Are you on a special diet? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No

Women: Are you

Pregnant/trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Local Anesthetics

○ Other, please explain:_____

Do you have or have you had any of the following?

AIDS/HIV positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilla	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Rheumatism	○ Yes ○ No
Anemia	○ Yes ○ No	Easily winded	○ Yes ○ No	Herpes	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood pressure	○ Yes ○ No	Shingles	○ Yes ○ No
Arthritis/gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Artifical heart valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Asthma	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Disease	○ Yes ○ No	Fainting spells/dizziness	○ Yes ○ No	Kidney problems	○ Yes ○ No	Stomach/intestinal Disease	○ Yes ○ No
Blood transfusion	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Leukemia	○ Yes ○ No	Stroke	○ Yes ○ No
Breathing problem	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Liver Disease	○ Yes ○ No	Swelling of limbs	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Frequent headaches	○ Yes ○ No	Low blood pressure	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Cancer	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Lung Disease	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Glaucoma	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Chest pains	○ Yes ○ No	Hay Fever	○ Yes ○ No	Pain in Jaw Joint	○ Yes ○ No	Tumors or growths	○ Yes ○ No
Cold sores/fever blister	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Congenital heart Disorder	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart pace maker	○ Yes ○ No	Radiation Treaments	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Heart trouble/Disease	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No		

Have you ever had any serious illness not listed above? ○ Yes ○ No If Yes, please explain:_____

Comments:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be danferous to my (or patients) health. It is my responsibility to inform the dental office of any changes in the medical status.

Signature of the Patient, Parent or Guardian_____ Date_____

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RELEASE OF RECORDS

I _____DO HEREBY AUTHORIZE THE RELEASE OF ALL RADIOGRAPHS AND DAILY TREATMENT NOTES T0 THE OFFICE OF ARNOLD E. BENAK JR.,DMD, LLC FROM _____

_____

I ALSO RELEASE ARNOLD E. BENAK JR., DMD, LLC FROM ALL LEGAL RESPONSIBILITY THAT MAY ARISE FROM THIS AUTHORIZATION.

SIGNATURE: _____ DATE:_____

PRINT NAME:_____

ADDRESS:_____

_____

PATIENT NUMBER: _____

PATIENT NAME:_____
Last First Initial

I HEREBY AUTHORIZE PAYMENT DIRECTILY TO _____
Dentist Name

OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME.

Signature of insured_____ Date:_____

SIGNATURE IS VALID FOR TWO YEARS FROM THE ABOVE DATE UNLESS REVOKED BY ME AT AN EARLIER DATE.

Attending DDS Name: ARNOLD BENAK JR. DMD, LLC

317 FLANDERS ROAD
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THE ABOVE NAMED IS AUTHORIZED TO PROVIDE ANY INSURANCE COMPANY(S), CLAIM ADMINSTRATIOR(S) AND CONSULTING HEALTH PROFESSIONALS INFORMATION CONCERNING HEALTH CARE ADVICE, TREATMENT, OR SUPPLIES PROVIDED. THIS INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATING ADMINISTRATING CLIAMS FOR BENEFITS.

THIS AUTHORIZATION IS VALID FOR THE TERM OF COVERAGE OF THE POLICY/CONRACT ENFORCED ON THIS DATE ONLY OR FOR TWO YEARS WHICH EVER IS SHORTER.

I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST AND AGREE THAT THE PHOTOGRAPHIC COPY OF THIS AUTHORIZATION IS VALID AS THE ORIGINAL.

_____
PATIENT OR PARENT/GAURDIAN'S SIGNATURE DATE

SIGNATURE ON FILE