Welcome to our office!!

Name: ____
Last First MI Title

Preferred Name: ______________________ Gender: __________ DOB: __________

Address: ______________________________City: __________ State: _____ Zip: _______

SS#: ____________ Driver License: __________E-mail Address: ____________________

Home Phone: ______________ Work Phone: ______________Cell Phone: ____________

Employer: __________________________ Occupation: ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about our office? ____

Preferred Pharmacy: __________________ Telephone: ______________________

Emergency contact person and phone number: ____________________________________

Patient Consent for Electronic Communication

You have requested that our practice communicates with you electronically. By utilizing our practice's electronic services, you agree that **Benoit Family Dental** may send to you any of the following that you identify as communication that can be transmitted through phone (text) or the internet to an email address you designate.

Consent and Acknowledgement

I______________________________________, in the presence of my dentist or the dental practice's privacy official, agree that the practice may electronically communicate with me at the following email address.

Email Address______________________________

I acknowledge that the practice may send the following to my email/phone/text. Check each that applies and then provide your initials at the end of each item selected.

Information about my invoice or accounts payable. ______ (initials)

Information about a specific dental visit. ______ (initials)

Information about any dental visit. ______ (initials)

I would like to receive a reminder of my appointment by:

Email Y / N Phone Call Y / N Texting Y / N Mobile # ______________

Acknowledgment

You must acknowledge each of the following before we can send communications electronically.

_______All electronic communications from our practice will be encrypted.

_______I am responsible for providing the dental practice any updates to my email address.

_______I am able to receive information electronically and store it securely away from any public computer.

_______I can withdraw my consent to electronic communications by calling ***713-529-3069*.**

Consent of Notice of Privacy Practices

I acknowledge that I have read and understand the HIPAA Notice of Privacy Practices for Protected Health Information.

Patient's Signature____________________________________ Date____________

Benoit Family Dental
1213 Hermann Dr. Suite 275 Houston, TX 77004 | 713.529.3069 | fax 713.529.3071 | info@drbenoitdds.com
drbenoitdds.com

MEDICAL HEALTH HISTORY

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

(Please check any that apply)

☐ YES ☐ NO Cancer or tumor
☐ YES ☐ NO Heart ailment or angina
☐ YES ☐ NO Heart Murmur, mitral valve prolapse Heart defect
☐ YES ☐ NO Rheumatic fever or rheumatic heart disease
☐ YES ☐ NO Artificial joint or valve
☐ YES ☐ NO Asthma
☐ YES ☐ NO High or low blood pressure
☐ YES ☐ NO Pacemaker
☐ YES ☐ NO Tuberculosis or other lung problems
☐ YES ☐ NO Kidney disease
☐ YES ☐ NO Hepatitis or other liver disease
☐ YES ☐ NO Alcoholism
☐ YES ☐ NO Blood transfusion
☐ YES ☐ NO Diabetes
☐ YES ☐ NO Neurologic condition
☐ YES ☐ NO Epilepsy, seizures, or fainting spells
☐ YES ☐ NO Arthritis
☐ YES ☐ NO Herpes or cold sores
☐ YES ☐ NO AIDS or HIV positive
☐ YES ☐ NO Migraine headaches or frequent Headaches
☐ YES ☐ NO Anemia or blood disorders
☐ YES ☐ NO Abnormal bleeding after extractions, Surgery, or trauma
☐ YES ☐ NO Hayfever or sinus trouble
☐ YES ☐ NO Allergies or hives

Do you smoke or use chewing tobacco? ☐ YES ☐ NO

Are you allergic to, or have you reacted adversely to Any of the following?

☐ YES ☐ NO Latex materials
☐ YES ☐ NO Penicillin or other antibiotics
☐ YES ☐ NO Local anesthetics (“Novocain”)
☐ YES ☐ NO Codeine or other narcotics
☐ YES ☐ NO Sulfa drugs
☐ YES ☐ NO Barbiturates, sedatives, or sleeping pills
☐ YES ☐ NO Sulfite or Bisulfite
☐ YES ☐ NO Aspirin
☐ YES ☐ NO Other:

____

Are you taking any of the following

☐ YES ☐ NO Aspirin
☐ YES ☐ NO Anticoagulants (blood thinners)
☐ YES ☐ NO Antibiotics or sulfa drugs
☐ YES ☐ NO High blood pressure medicine
☐ YES ☐ NO Antidepressants or tranquilizers
☐ YES ☐ NO Insulin, Orinase, or other diabetes drug
☐ YES ☐ NO Nitroglycerin
☐ YES ☐ NO Cortisone or other steroids
☐ YES ☐ NO Osteoporosis (bone density) medicine
☐ YES ☐ NO Other:

____
____

Women:

☐ YES ☐ NO May be pregnant
Expected delivery date: _____
☐ YES ☐ NO Taking hormones or contraceptives

Physician Name: ______________________________ Physician Phone Number: ______________________

List any medication you are taking: ____

Do you have any disease, condition, or problem not listed above? ______________________________

Please add anything else you would like us to know about your oral hygiene: ____________________

The information above is correct to the best of my knowledge. I give my consent to have the necessary treatment recommended for my benefit (or my minor) only after it has been mutually approved.

Signature of patient (or parent): ______________________________ Date: ________________