Frank P. Benson, D.M.D.

Periodontics . Implant Dentistry . TMD/Facial Pain

Patient's Name Nickname

Address

City State Zip Birthdate

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed

Social Security Number Occupation Company

Home Phone Work Phone + Extension Cell Phone

E-mail Address General Dentist Referring Doctor

If different, give the person's name responsible for account or person's name with insurance:

Name Social Security Number

Address Company

City State Zip Birthdate

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed

Contact for Emergency:

Name Relation

Address City State Zip

Home Phone Work Phone + Extension Cell Phone

1140 Hammond Drive • Building G • Suite 7200 • Atlanta, Georgia 30328
Phone: (770) 394-0007 • Fax: (770) 394-7171 • E-mail: info@drfrankbenson.com

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Dental Health History:

	Yes	No
Have you had regular dental care in the past?	☐	☐
Are you happy with the appearance of your teeth?	☐	☐
Do you chew on both sides of your mouth?	☐	☐
Are you please with your dental health?	☐	☐
Do your gums bleed when brushing?	☐	☐
Is there any unusual swelling in your mouth?	☐	☐
Are you frightened by dental treatment?	☐	☐
Have you at any time in your life worn braces?	☐	☐
Do you or have you ever had periodontal disease?	☐	☐

Are your teeth sensitive to: (check all that apply)
☐ Cold ☐ Hot ☐ Sweets ☐ Biting Pressure

Do you have unusual or frequent pain in:
(check all that apply) ☐ Teeth ☐ Jaw Joints ☐ Ears

Date and type of your last x-ray_______________

Doctor who took your last x-ray_______________

Medical Health History: General

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

If yes, for what reason: ___________________________

Physician's Name:________________________________

Phone number:___________________________________

Please list all medication or drugs from the past two years through present:____

____

Are you allergic to or have you ever reacted adversely to any medication or substance? ☐ Yes ☐ No
If yes, please list_________________________________

____

Do you use any tobacco products? ☐ Yes ☐ No
If yes, for how long________And how often_________

Do you or have you had any of the following: **(check all that apply)**

☐ Heart Disease/Attack	☐ Artificial Heart Valve	☐ Kidney Trouble	☐ Hepatitis B(serum)	☐ Asthma
☐ Rheumatic Fever	☐ High Blood Pressure	☐ Arthritis	☐ Glaucoma	☐ A.I.D.S.
☐ Heart Mumur	☐ Heart Surgery	☐ Drug Addiction	☐ Tuberculosis	☐ H.I.V. Positive
☐ Epilepsy or Seizures	☐ Hemophilia	☐ Ulcers	☐ Radiation Therapy	☐ Fever Blisters
☐ Mitral Valve Prolapse	☐ Liver Disease	☐ Diabetes	☐ Chemotherapy	☐ Cold Sores
☐ Heart Pacemaker	☐ Thyroid Problems	☐ Artificial Joint	☐ Hepatitis A	☐ Osteoporosis

Medical Health History: Women Only

Do you take oral contraceptives? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No
If yes, what month are you currently in?________

Patient Acknowledgement: By my signature, I have read and understand the policies of this office.

Print Name Signature Date

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