Joseph A. DiBenedetto, D.M.D.
3211 Sunset Avenue
Ocean, NJ 07712
Phone: 732-988-7272

Patient Information

Patient Name: ____________________ Date:____________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other____________

Social Security #: ____________________ Birth Date:____________________

Phone (Home): ____________ (Work): ____________ Ext:______ Cellular #:____________

E-Mail Address:____

Address: ____

____

Emergency contact (Name)____________________(Phone)____________

Health Information

Date of Last Dental Visit: ____________ Reason for this visit:____________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV Infection
☐ Allergies ___________
____
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chest Pain/Angina
☐ Diabetes
☐ Emphysema
☐ Epilepsy/Seizures
☐ Excessive Bleeding

☐ Fainting/ Dizziness
☐ Glaucoma
☐ Growths
☐ Head Injuries
☐ Heart Disease/Surg
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse

☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:__________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Smoked Cigarettes
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers

☐ Other Med Conditions
____
____
____

☐ Codeine Allergy
☐ Penicillin Allergy
☐ **Allergic to any other .....Medications?**
____
____
____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____

- Please list any medications you are taking____
____

- Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain:____________
____

- Name of Physician: ____________________ Phone:____________

- **Do you smoke?** Yes _______ No_______ • **Have you ever taken Phen-Fen/Redux?** Yes______ No______

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date:____________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ____________________

Spouse / Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ____________ (Work): ____________ Ext:______ Best time to call: __________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ______________________________
Street City State Zip Code

Insurance Information

Primary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ______________ Group #:______________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ______________________________

____

Secondary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ______________ Group #:______________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address: ______________________________

____

Consent for Services

I hereby certify that I have read and understand the above information and have answered the questions accurately. I understand that giving incorrect information could be dangerous to my health. I understand that this information will be held in the strictest of confidence, and that it is **my responsibility** to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services, including local anesthetic that I may need during diagnosis and treatment. I authorize the dentist to release records and any information he deems necessary to any third party payors and/or health practitioners. I authorize and request that my insurance carrier pay the dentist directly benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for the unpaid remaining balance. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

______________________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________
Signature of guarantor of payment/responsible party