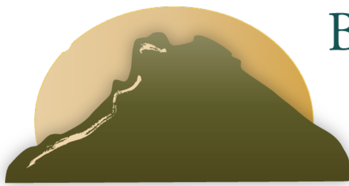

BENJAMIN T. PETERSON, DDS, PC

271 SW 13th St. | Ontario, OR | 97914
(541) 889-9407 | www.bpetersondds.com

PATIENT INFORMATION Date: ____________

Patient Name: ________________________________

Address: ____________________________________

City: ____________________ State:____ Zip: ______

Gender: □ Male □ Female Age: ______

Birthdate: ___________ SSN: __________________

□ Married □ Single □ Other □ Minor

Patient Employer: _____________________________

Email address: _______________________________

Spouse or Parent(s) Name:

____

Whom may we thank for referring you to our office?

____

DENTAL INSURANCE

Insurance Company: ________________________________

Subscriber's Name: _________________________________

Birthdate: _________________ SSN: __________________

Policy/ID#: ____________________ Group#: ____________

Relationship to patient: ______________________________

SECONDARY INSURANCE? □ Yes □ No

Insurance Company: ________________________________

Subscriber's Name: _________________________________

Birthdate: _________________ SSN: __________________

Policy/ID#: ____________________ Group#: ____________

PHONE NUMBERS Home: ____________________ Cell: _____________________ Work: _____________________

Which number would you prefer to be reached at? Home Cell Work

Emergency Contact: _________________________ Relationship: ________________ Phone: ____________________

PAYMENT POLICY Payment is expected at the time services are rendered unless prior arrangements have been made. We expect that your account will be cleared within 60 days. If financial arrangements have been made, the remaining unpaid balance may be subject to a FINANCE CHARGE at the ANNUAL PERCENTAGE RATE of 18%. There will be a $25 fee for all returned checks.

INSURANCE ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have the insurance coverage referenced above and assign directly to Benjamin T. Peterson, DDS, PC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. Benjamin T. Peterson, DDS, PC, may use my health care information and may disclose such information to the above-named insurance company and its agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This release of information will remain in effect until revoked by me in writing.

____
Signature of Patient or Responsible Party

____
Please print name of Patient or Responsible Party

____
Date

____
Relationship to Patient

DENTAL HISTORY

Reason for today's visit: ___________________________

Former Dentist: _________________________________

Date of last dental visit: ____________________________

Date of last dental x-rays: __________________________

Are you happy with the condition of your teeth? □Yes □ No

If not, why? __________________________________

____

____

____

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

□ Bad breath
□ Bleeding gums
□ Clicking or popping of the jaw
□ Food collection between teeth
□ Loose teeth or broken fillings
□ Periodontal treatment
□ Grinding teeth
□ Sensitivity to cold
□ Snoring
□ Sensitivity to hot
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sores or growths in mouth