Mark Bernsdorf, DDS

CREATING SMILES FOR 35 YEARS

W E L C O M E !

We are pleased to welcome you to our practice. Please fill out this form as completely as you can. If you have questions, please contact us at 614-771-7788 or BernsdorfStaff@yahoo.com. This form can be returned by e-mail, fax to 614-771-7876 or by mail to: Mark Bernsdorf DDS, 3720 Ridge Mill Drive, Suite C, Hilliard, Ohio 43026.

Patient Information

Name_____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address_____

City_____ State_____ Zip_____ Home Phone_____

Cell Phone_____ E-mail_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Business E-mail _____

Whom may we thank for referring you?_____

Notify in case of emergency_____ Home phone_____

Cell Phone_____ Business Phone_____

E-mail _____

Primary Insurance

Person Responsible for Account_____
Last name *First name* *Initial*

Relation to Patient_____ Birthdate_____ Soc. Sec. #_____

Address (if different from patient)_____ Home phone_____

City_____ State_____ Zip_____

Cell Phone_____ E-mail_____

Person Responsible Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Business E-mail_____

Insurance Company _____Phone_____

Insurance E-mail _____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents under this plan_____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address (if different from patient)_____ Soc. Sec. #_____

City_____State_____ Zip_____ Home Phone_____

Cell Phone_____ E-mail_____

Subscriber Employed by_____ Business Phone_____

Business E-mail_____

Insurance Company_____ Phone_____

Insurance E-mail_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents under this plan_____

Dental History

What would you like us to do today?_____ Are you in dental discomfort today? _____

Former Dentist_____ Address_____

Dentist's E-mail_____ Phone_____

Date of last dental care _____ Date of last X-rays_____

Check yes or no if you have had problems with any of the following:

☐ Y ☐ N Bad breath
☐ Y ☐ N Bleeding gums
☐ Y ☐ N Clicking or popping jaw
☐ Y ☐ N Food collection between teeth
☐ Y ☐ N Grinding or clenching teeth
☐ Y ☐ N Loose teeth or broken fillings
☐ Y ☐ N Periodontal treatment
☐ Y ☐ N Sensitivity to cold
☐ Y ☐ N Sensitivity to hot
☐ Y ☐ N Sensitivity to sweets
☐ Y ☐ N Sensitivity when biting
☐ Y ☐ N Sores or growths in mouth

How often do you brush?_____

How do you feel about the appearance of your teeth?_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Other information about your dental health or previous treatment_____

Medical History

Physician's name_____ Phone_____

Date of last visit_____ Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe_____

Are you currently under physician care? ☐ Yes ☐ No If yes, describe_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates_____

Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check yes or no whether you have had any of the following:

☐ Y ☐ N AIDS/HIV Positive
☐ Y ☐ N Anaphylaxis
☐ Y ☐ N Anemia
☐ Y ☐ N Arthritis, Rheumatism
☐ Y ☐ N Artificial heart valves
☐ Y ☐ N Artificial joints
☐ Y ☐ N Asthma
☐ Y ☐ N Atopic (allergy prone)
☐ Y ☐ N Back problems
☐ Y ☐ N Blood disease
☐ Y ☐ N Cancer
☐ Y ☐ N Chemical dependency
☐ Y ☐ N Chemotherapy
☐ Y ☐ N Circulatory problems
☐ Y ☐ N Cortisone treatments
☐ Y ☐ N Cough, persistent
☐ Y ☐ N Cough up blood
☐ Y ☐ N Diabetes
☐ Y ☐ N Epilepsy
☐ Y ☐ N Fainting
☐ Y ☐ N Food allergies
☐ Y ☐ N Glaucoma
☐ Y ☐ N Headaches
☐ Y ☐ N Heart murmur
☐ Y ☐ N Heart problems
Describe_____
☐ Y ☐ N Hemophilia/Abnormal bleeding
☐ Y ☐ N Herpes
☐ Y ☐ N Hepatitis
☐ Y ☐ N High blood pressure
☐ Y ☐ N Jaw pain
☐ Y ☐ N Kidney disease or malfunction
☐ Y ☐ N Liver disease
☐ Y ☐ N Material allergies (latex, wool, metal, chemicals)
☐ Y ☐ N Mitral valve prolapse
☐ Y ☐ N Nervous problems
☐ Y ☐ N Pacemaker/Heart surgery
☐ Y ☐ N Psychiatric care
☐ Y ☐ N Radiation treatment
☐ Y ☐ N Rapid weight gain or loss
☐ Y ☐ N Respiratory disease
☐ Y ☐ N Rheumatic/Scarlet fever
☐ Y ☐ N Shingles
☐ Y ☐ N Shortness of breath
☐ Y ☐ N Skin rash
☐ Y ☐ N Spina Bifida
☐ Y ☐ N Stroke
☐ Y ☐ N Surgical implant
☐ Y ☐ N Swelling of feet or ankles
☐ Y ☐ N Thyroid disease or malfunction
☐ Y ☐ N Tobacco habit
☐ Y ☐ N Tonsillitis
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Ulcer/Colitis
☐ Y ☐ N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance.

Signature_____ Date_____

Payment is due in full at time of treatment, unless prior arrangements have been approved.