BRADY BENSON, D.D.S.,P.C.
111 EAST FOREST, SUITE F
BRIGHAM CITY, UT 84302
(435) 723-2318

PATIENT'S NAME_____

HEALTH QUESTIONNAIRE ACKNOWLEDGMENT AND CONCENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge**. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.**

I authorize Dr. Benson and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or other administration of any sedative (including nitrous oxide), analgesic, therapeutic and/or pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness; and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions. After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek, or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and significant risk of serious harm, if any, which may be associated with any phase of standard dental preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or for the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient name: (Print)_____

Signature:_____Date_____
{Patient, legal guardian or authorized agent of patient)

Witness:_____Date_____

Brady E. Benson, D.D.S.,P.C.
111 East Forest, Suite F
Brigham City, UT 84302

PATIENT INFORMATION Date:_____

Name:_____SSN:_____Birth date:_____

Address:_____City_____State_____Zip_____

Home Phone:_____Cell:_____ Sex: M F Marital Status: M S W D

E-mail address:_____ Preferred Pharmacy:_____

Employer:_____Phone:_____

Student? F/T P/T Name of School:_____

Spouse:_____SSN:_____Birth date:_____

Employer:_____Phone:_____

Emergency Contact Person:_____Relationship:_____

Address:_____Phone:_____

Whom may we thank for referring you?_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person:_____Relationship:_____Birth date:_____

Residence Address:_____City_____State_____ Zip_____

Phone #:_____SSN:_____

Employer:_____# of years employed_____

Employers Address:_____City_____State_____Zip_____

PRIMARY INSURANCE

Insurer's Name:_____SSN:_____Birth date_____

Patient's Relationship to Insured: Self:___Spouse:___Child:___ Other:___

Employer:_____Phone#:_____

Insurance Company_____Group#:_____Carrier ID#_____

SECONDARY INSURANCE

Insurer's Name:_____SSN:_____Birth date_____

Patient's Relationship to Insured: Self:___Spouse:___Child:___Other:___

Employer:_____Phone#:_____

Insurance Company:_____Group#:_____Carrier ID#_____