Dr. Michael Bensky and Associates

Welcome to Our Office

We are committed to giving our patients the best dental care possible. In order to do so, it is imperative that each patient provide us with relevant information. Please answer all the questions on both sides. All information will be kept confidential.

Personal Information

Name_____Date of Birth_____Age__
By what name would you like to be called_____
Address_____, City_____ Prov____
Postal Code_____, Gender M / F
Home phone_____ Cell _____Work Phone_____,
email address_____@_____,
Marital Status_____Spouse's name if applicable_____
Whom may we thank for referring you?_____
In case of emergency notify?_____

Medical History

Family Doctor_____ Phone #_____

1. Have you had any serious illnesses or operations and if so explain_____
   _____
2. Are you under the care of a physician presently for any problems and is so explain,
   _____
3. Have you had a medical exam within the last year?_____ Any Problems_____
4. Are you presently taking medications or have in the past 3 months?_____
   If yes, what?_____
5. Do you have any artificial joints or other artificial parts? Y / N , _____
6. Any drug/non-drug allergies and if so what?_____
7. Any serious problems or conditions that require antibiotics for dental treatment? Y / N
8. Do you have a pacemaker or artificial heart valve? Y / N
9. Do you bleed or bruise easily?
10. Are you taking medication for osteoporosis?
11. Have you ever fainted and if so why?_____
12. Do you have shortness of breath or chest pains? Y / N _____
13. Have you gained or lost excessive weight recently? Y / N
14. Have you had an increase in thirst, appetite of frequency of urination ? Y / N
15. Is there a history of family disease? if so what?_____
16. Is there anything else that the dentist should be made aware of?_____
17. For women: Are you Pregnant? Y ?/ N, Nursing Y / N, On BC meds? Y / N
18. Do you have any of the following? Please circle, AIDS/HIV , Anemia, Asthma,Cancer
    Blood Disorders, Heart Trouble, Heart Murmur, High Blood Pressure, Diabetes,
    Epilepsy, Liver disease/Hepatitis, Lung Disease, Mental/Nervous Disease,
    Rheumatic Fever, Thyroid Disease, Radiation Therapy, Sinusitis, Venereal Disease

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Previous Dentist_____, Phone #_____
How frequently do you see a dentist?_____ Last visit_____

2. Have you ever been given oral hygiene instruction in brushing, flossing ,other? Y / N
3. Have you ever had local anaesthetic? Y / N , any problems? _____
4. Have you ever had relaxation techniques ie. laughing gas etc? Y / N
5. Are any of your teeth sensitive to COLD, SWEET, HEAT, OTHER circle which one
6. Do your gums bleed when BRUSHING, FLOSSING, SPONTANEOUSLY
7. Do your gums feel swollen or tender? Y / N
8. Do you catch food between your teeth? Y / N
9. Do you have any loose teeth?
10. Does your jaw crack, pop or grate when you open widely? Y / N
11. Do you grind or clench your teeth while you sleep? Y / N
12. Do you wake up with headaches ? Y / N
13. Are you satisfied with the appearance of your teeth? Y / N
14. Have you ever considered bleaching your teeth? Y / N
15. Do you consider your teeth beyond treatment ? Y / N
16. Do you have some missing teeth and are considering replacing them? Y / N
17. Are you anxious to keep your natural teeth? Y / N
18. Would you like to upgrade the appearance of your smile? Y / N

Parents consent for children under 18 (if applicable)

I hereby consent to the performing of dental and oral surgery procedures necessary or advisable for my child as outlined to me including the use of local anaesthetic and/or nitrous oxide as indicated and I accept the responsibility for the fee.

Parent signature_____ Date_____

Patient Certification and Approval

I, the undersigned, certify that all the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. In addition, I understand that I am responsible for all charges incurred. I realize that third party coverage (when applicable) may not necessarily cover all of my expenses and that I am responsible for any differences, deductibles or co-payments.

Signature_____ Date_____