RUSHMORE DENTAL

About You

Today's Date:_____ Email Address:_____

Name:_____ I preferred to be called:_____ M__ F__

Birth Date:__/__/____ Age:____SS#_____

Previous/ Present Dentist:_____ Last Visit_____

Home Address: _____ City/State/Zip:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Employer:_____Employer Address:_____

How long there?_____Occupation:_____Other Family members seen by us? Y/N

Where & When is the best time to reach you?_____

Whom may we thank for referring you?_____

Spouse Information

His/Her Name:_____Employer:_____

Work Phone:_____SS#_____Birthdate:_____DL#_____

Person Responsible for Account:_____

Work Phone:_____Home Phone:_____Relationship:_____

SS#_____Employer:_____DL#_____

Insurance Information

Primary Insurance company name:_____Dental Coverage? **Y / N**

Insurance Co. Address:_____Insurance Co. phone#_____

Group#(Plan, Local, or Policy#)_____ Insured's ID#:_____

Insured's Name:_____ Relation:_____

Insured's Birthdate:_____ Insured's employer:_____

Employer's address:_____Employer's phone_____

Secondary Insurance company name:_____Dental Coverage? **Y / N**

Insurance Co. Address:_____Insurance Co. phone#_____

Group#(Plan, Local, or Policy#)_____ Insured's ID#:_____

Insured's Name:_____ Relation:_____

Insured's Birthdate:_____ Insured's employer:_____

Employer's address:_____Employer's phone_____

Dental History

Why have you come to the dentist today?_____

Do you require antibiotics before dental treatment? **Y / N** Are you currently in pain? **Y / N**

Have you ever had a serious/difficult problem with any previous dental work? **Y / N**

You current dental health is : **Good / Fair / Poor** Have you ever had gum treatment? **Y /N**

Do you now or have you ever experienced pain/ discomfort in you jaw joint(TMJ/TMD)? **Y /N**

Do you like your smile? **Y / N** Do your gums ever bleed? **Y / N**

How many times a week do you floss?_____How many times a day do you brush?_____

Type of bristles? **Soft / Medium / Hard** How long do you wait to before replacing it?____

Are your teeth sensitive to heat, cold, or anything else?_____

Have you lost any teeth? **Y / N** If yes, why?_____

Medical History:

Do you have a Physician? **Y / N** Physician's name:_____

Physician's Phone #_____ Date of last visit:_____

Are you currently under the care of a physician? **Y / N** Please Explain: _____

_____

Your Current Physical health is: **Good / Fair / Poor**

Have you had any metal rods, pins, or implants? **Y / N**

Do you smoke or use tobacco in any form? **Y / N**

Are you taking any prescription/ over-the-counter or herbal supplement drugs? **Y / N** Please list each one:_____

_____

_____

_____

Do you have any allergies to medications? **Y/N**

If yes please list: _____

Other Allergies**:**

_____

Latex Y / N **Metals/nickel Y / N** **Plastics Y / N**

Have you ever taken Fosamax, Actonel, Boniva or any other bisphosonate? **Y / N**

Have you ever had any of the following diseases or medical problems?

Y / N	Abnormal Bleeding	**Y / N**	Glaucoma	**Y / N**	Osteoporosis I Paget's Disease
Y / N	Alcohol/ Drug Abuse	**Y / N**	Hay Fever	**Y / N**	Pacemaker
Y / N	Anemia	**Y / N**	Heart Attack	**Y / N**	Psychiatric Problems
Y / N	Arthritis	**Y / N**	Heart Murmur	**Y / N**	Radiation Treatment
Y / N	Artificial Bones/ Joints	**Y / N**	Heart Surgery	**Y / N**	Rheumatic/ Scarlet Fever
	Valves	**Y / N**	Hemophilia	**Y / N**	Seizures
Y / N	Asthma	**Y / N**	Hepatitis	**Y / N**	Shingles
Y / N	Blood Transfusion	**Y / N**	Herpes/ Fever	**Y / N**	Sickle Cell Disease I Traits
Y / N	Cancer/ Chemotherapy		Blisters	**Y / N**	Sinus Problems
Y / N	Colitis	**Y / N**	High Blood	**Y / N**	Stroke
Y / N	Congenital Heart		Pressure		
	Defect	**Y / N**	HIV+/ AIDS	**Y / N**	Thyroid Problems
Y / N	Diabetes	**Y / N**	Hospitalized for	**Y / N**	Tuberculosis
Y / N	Difficulty Breathing		any reason	**Y / N**	Ulcers
Y / N	Emphysema	**Y / N**	Kidney Problem	**Y / N**	Venereal Disease
Y / N	Fainting Spells	**Y / N**	Liver Disease	**Y / N**	Low Blood Pressure
Y / N	Frequent Headaches	**Y / N**	Lupus	**Y / N**	Mitral Valve Prolapse

FOR WOMEN: Are you using a prescription method of birth control? **Y / N**

Are you pregnant? **Y / N** Week #_____ Are you nursing? **Y / N**

I understand that in information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

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

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandates by OSHA, the CDC and the ADA