

Welcome to the office of Dr. Daniel C. Bush

Patient Information

Patient Name: _____ Date: _____
Last First MI
 Mr. Mrs. Ms. Dr. Other _____ I prefer to be called: _____
 Male Female Married Single Child Widow Divorced Separated
Social Security # _____ Birth Date: _____
Address: _____
Street Apartment #
City State Zip Code
Phone Hm: _____ Cell: _____ Wk: _____
Email: _____ May we call you at work? Yes No
What is the best way to contact you? Home Work Cell Email
Would you like to receive appointment reminders via: EMAIL Yes No TEXT MESSAGE Yes No

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment – relationship to patient _____
Name: _____ Male Female
Last First MI
Social Security # _____ Birth Date: _____
Address: _____
Street Apartment #
City State Zip Code
Phone Hm: _____ Cell: _____ Wk: _____
Email: _____ May we call you at work? Yes No

Employment Information

The following is for: the patient the person responsible for payment Occupation: _____
Employer/Company Name: _____ Phone: _____
Address: _____
Street City State Zip Code

Insurance payments must be received within 60 days of the date of service, after 60 days patient is responsible for payment.

Insurance Information

Primary
Name of Insured: _____ Birth Date: _____
Last First MI
Relationship to patient: Self Spouse Parent or Guardian Other _____
Social Security # _____ ID #: _____ Group # _____
Insurance Plan Name: _____ Phone: _____
Address: _____
Street City State Zip Code
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Do you have dual coverage? Yes No If yes, please provide additional coverage info. on the reverse side so we can assist you in filing for reimbursement. **Sorry, we do not accept assignment of benefits on secondary insurance. ➡➡**

Additional Insurance Information

Secondary

Name of Insured: _____ Birth Date: _____
Last First MI

Relationship to patient: Self Spouse Parent or Guardian Other _____

Social Security # _____ ID #: _____ Group # _____

Insurance Plan Name: _____ Phone: _____

Address: _____
Street City State Zip Code

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? Sign Internet Other Dental Office Yellow Pages
 Work Another patient, friend Another patient, relative Other _____

Name of person referring you to our practice: _____

Financial Agreement & Consent for Services

The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. As a condition of treatment by this office the patient/responsible party understands that all dental services performed are charged directly to the patient and payment in full will be due at the time treatment is performed, unless financial arrangements have been made in advance.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that this office cannot render services on the assumption that our charges will be paid by an insurance company and that he or she is personally responsible for payment of all dental services. Our office will help prepare the patients insurance forms to assist in making collections from insurance companies, and when arrangements are made in advance our office will credit such collections to the patient's account. However, patient understands that any unpaid insurance balance after 60 days and any balance not satisfied by insurance regardless of the basis for nonpayment are the responsibility of the patient, due in full upon receipt of billing statement.

A monthly service charge of \$25 on unpaid balances may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services to be rendered to me by the office of Dr. Daniel C. Bush, I grant my permission to you or your assignee to telephone me to discuss matters related to this form, finances, and/or treatment. I agree to pay therefore the reasonable value of said services to Dr. Bush, or his assignee, at the time services are rendered or according to the financial arrangements made. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

My signature below represents that I have read the above and agree to the entire content, and authorize Dr. Bush and/or his dental staff to perform dental services I may need during diagnosis and treatment.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____

Thank you for choosing our office to meet your dental health needs. Please provide us with medical and dental history information by answering the questions below and on the reverse side of this form. ➡

Health Information

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS or HIV Positive | <input type="checkbox"/> Fainting | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergic Reactions | <input type="checkbox"/> Fever Blisters/Herpes | <input type="checkbox"/> Major Hospitalizations | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent Snoring | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths/Tumors | <input type="checkbox"/> Nervous Disorders | |
| <input type="checkbox"/> Artificial Joints/Valves | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | OTHER: |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Respiratory Problems | ALLERGIES: |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Sexual Trans Disease | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sleep Apnea | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | |

Your current physical health is Good Fair Poor

• Do you now or have you ever taken **Bisphosphonates** (bone density enhancement) Ex: Fosamax, Actonel, Boniva?

Yes No If yes, please list drug Name: _____ Dosage: _____ How long? _____

• Are you currently taking any medication (**including over-the-counter drugs/vitamins**)? Yes No

If yes, please list: _____

• Have you had any reaction to medications, such as codeine, etc.? Yes No

If yes, please list: _____

• Do you have a personal physician? Yes No Date of last physical exam: _____

Name of Physician: _____ Phone: _____

• Are you currently under the care of a physician? Yes No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

• Do you smoke or use smokeless tobacco? Yes No If yes, how much? _____

Would you like information to help you quit? Yes No

• Do you consume alcoholic beverages? Yes No

• Are you currently using any illegal drugs? Yes No

For Women

• Are you taking birth control pills? Yes No

• Are you pregnant? Yes No If yes, due date _____

• Are you nursing? Yes No

Please provide Dental information on reverse side. ➡ ➡

Dental Information

Date of Last Dental Visit: _____ **Reason for this visit:** _____

• Why have you come to the dentist today? _____

• Are you currently in pain or do you have any dental problems? Yes No
If yes, please explain: _____

• Are any of your teeth sensitive to cold, heat, or anything else? Yes No
If yes, please explain: _____

• Have you ever had complications / difficult problem associated with previous dental treatment? Yes No
If yes, please explain: _____

• **Do you need to be pre-medicated w/antibiotics prior to having dental treatment?** Yes No
If yes, with what medication: _____

• Do you floss your teeth daily? Yes No

• Do your gums bleed easily when brushing or flossing? Yes No

• Do your gums feel swollen or painful? Yes No

• Have you been told or do you feel you have gum (periodontal) problems? Yes No

• Do you feel it is important to keep your natural teeth? Yes No

• Do you have problems chewing or swallowing your food? Yes No

• Do you have pain, discomfort, or clicking in your jaw joint when chewing? Yes No

• Do you wake up in the morning with a headache? Yes No

• Do you often have headaches and/or tired chewing muscles? Yes No

• Do you grind your teeth? Yes No

• Have you ever had orthodontics? Yes No

• Have you ever had oral surgery? Yes No

• Are you wearing removable dental appliances? Yes No

• Do you snore? Yes No

• Are you nervous about dental treatment? Yes No

• What can we do to make you most comfortable? _____

• Are you unhappy with the appearance of your smile Yes No Rate your smile: (yuk!) 1 2 3 4 5 (smiles!)

If yes, please explain: _____

• Do you have any other condition or disease you think the doctor should know about? Yes No

If yes, please explain: _____

• Is there anything you would like to discuss with the doctor in private? Yes No

To the best of my knowledge all of the information I have given is true and correct. If I ever have any changes in my health I will inform the doctor at the next appointment without fail.

Signature of patient, parent or guardian

Date: _____