Bush Dentistry

4112 6th Avenue | Kearney NE, 68845 | 308-236-9694

Name:_____ Birthday_____ SSN#_____

Preferred Name:_____ **E-Mail**_____

Address_____ City _____ State_____ Zip_____

Home Phone ( )_____**Work Phone** ( ) _____Ext. _____**Cell Phone** ( ) _____

I would like to be notified of my appointments by E-mail ☐ Text message ☐ Phone call ☐

Sex: ☐ **M** ☐ **F** **Status**: ☐ Married ☐ Widowed ☐Single ☐ Minor ☐ Separated ☐ Divorced

If a Student, Name of School/College _____City_____State_____ ☐ Full- time ☐ Part-time

Patient's Employer _____Occupation _____

Spouse or Emergency contact _____Employer_____Work Phone_____

RESPONSIBLE PARTY

Name of person Responsible for this account_____Relationship to patient _____

Address _____Home Phone _____Cell Phone_____

Social Security # _____ Birthdate_____

Employer_____ Work Phone_____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is required at the time of service.

☐ Cash ☐ Personal check ☐ VISA ☐ Mastercard ☐ Discover ☐ CareCredit (flexible payment plan WAC)

Whom may we thank for referring you? _____

Primary Dental Insurance:

Name of Insured _____ Relationship to patient _____

Address of policy holder _____ City _____ zip _____
(if different from above)

Home Phone Number_____ Work Phone Number_____

Birthday_____ SSN/ID# _____

Insured's Employer _____Insurance Company _____

Insurance Company Address_____ City _____State _____Zip_____

Group Number _____**Policy ID #**_____Phone number_____

Is the patient covered by additional insurance: ☐ Yes ☐ No If yes Complete the following:

Additional Dental Insurance:

Name of Insured _____ Relationship to patient _____

Address of policy holder _____ City _____ zip _____

Home Phone Number_____ Work Phone Number_____

Birthday_____ SSN/ID# _____

Insured's Employer _____Insurance Company _____

Insurance Company Address_____ City _____State_____Zip_____

Group Number _____**Policy ID #**_____ Phone number_____

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MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Bush Dentistry

Dental History

Name:_____

Reason for your visit today

_____

Former Dentist _____ City/State _____

Date of last Dental exam _____Date of last dental x-ray _____

How often do you floss? _____ How often do you brush? _____ What type of toothbrush do you use? Soft ☐ Medium ☐ Hard ☐

Has fear or discomfort kept you from dental visits or cares? Yes ☐ No ☐ If yes, please Explain_____

Are you satisfied with the appearance of your teeth? Yes ☐ No ☐ If no, please Explain_____

Have you had any unusual reaction to dental anesthesia (gas or injections)? Yes ☐ No ☐ If yes, please explain_____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following :

Bad Breath	Yes ☐	No ☐	Jaw pain or tiredness	Yes ☐	No ☐
Bleeding gums	Yes ☐	No ☐	Lip or cheek biting	Yes ☐	No ☐
Pain around ear	Yes ☐	No ☐	Loose teeth or broken teeth	Yes ☐	No ☐
Blisters on lips or mouth	Yes ☐	No ☐	Mouth breathing	Yes ☐	No ☐
Burning sensation on tongue	Yes ☐	No ☐	Mouth pain, brushing	Yes ☐	No ☐
Chew on one side of mouth	Yes ☐	No ☐	Orthodontic treatment	Yes ☐	No ☐
Clicking or popping jaw	Yes ☐	No ☐	Periodontal treatment	Yes ☐	No ☐
Dry mouth	Yes ☐	No ☐	Dental Implant	Yes ☐	No ☐
Fingernail biting	Yes ☐	No ☐	Sensitivity to cold	Yes ☐	No ☐
Food collection between the teeth	Yes ☐	No ☐	Sensitivity to hot	Yes ☐	No ☐
Grinding teeth	Yes ☐	No ☐	Sensitivity to sweets	Yes ☐	No ☐
Gums swollen or tender	Yes ☐	No ☐	Sensitivity when biting	Yes ☐	No ☐
			Sores or growths in your mouth	Yes ☐	No ☐

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my or (dependents) health care, advice and treatment provided for the purpose of evaluating and Administering claims for insurance benefits.

I authorize release of any information concerning my (or dependents) health care and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

I understand that my dental insurance is a *contract between the insurance carrier and me* and not between the insurance carrier and the dentist, and that I am ultimately responsible for all dental fees. If payment from my insurance carrier is not received within 30 days, I understand that I will be responsible for payment of my treatment fees and collection of benefits directly from my insurance carrier.

I understand that I will be charged for all dental treatment and any payments received by the dental office from my insurance coverage will be credited to my account, or refunded to me if I have previously paid the dental fees incurred.

I understand that I am expected to pay the total amount of fees on the day of service. If I do not pay the entire amount, a finance charge will be added to the account for the current monthly billing period, which is an annual percentage rate of 18% applied to the last month's balance.

In case of default of payment I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

I understand that upon my request I will be provided with a copy of the HIPAA privacy policy.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date_____