RUSH
FAMILY DENTAL
family to family care

PATIENT ACQUAINTANCE FORM

Patient Name: ______________________ Phone Number: ______________________

Email Address: ______________________ Preferred Method of Contact: Text ☐ Call ☐ Email ☐

Sex: ________ Marital Status: ________ Birth Date: ________ Age: ______ SS#: ________

Address: ______________________ APT/CONDO # CITY/STATE ZIP CODE

Person responsible for account:(first/last name and relationship to patient) ______________ DOB: ________ Phone#: ________

Whom may we thank for referring you? ______________ Previous/Present Dentist: ______________

Emergency Contact: ______________ **Relationship:** ______________ Phone Number: ______________

Address: ______________________ APT/CONDO # CITY/STATE ZIP CODE Secondary Phone: ______________

Dental Insurance Co.: ______________________ Insurance Phone#: ______________

Policyholder Name: ______________ Employer Name: ______________ Group#: ______________

Policyholder Relationship to Patient: ______________ Policyholder DOB: ______________ SS/ID#: ______________

Secondary Insurance Co.: ______________________ Empl (H/R) Phone: ______________

Employer Address: ______________ Employer Name: ______________ Group#: ______________

Policyholder Relationship to Patient: ______________ Policyholder DOB: ______________ SS/ID#: ______________

How did you hear about our office? ______________________

Is there anything you would like to change about your smile? ______________________

DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING CONDITIONS? –INDICATE WITH AN (X)

- ○ Allergic to any drugs or anesthetics – Please List: ______________________
- ○ Do you now have or have you been exposed to HIV/AIDS?
- ○ Hepatitis or liver problems?
- ○ Joint replacement (Hip, knee, etc)? When? ______________
- ○ Any heart ailments (Vascular surgery, pacemaker)?
- ○ Mitral Valve Prolapse/Heart Murmur?
- ○ Rheumatic Fever?
- ○ Have you ever suffered a stroke?
- ○ Do you have high blood pressure?
- ○ Are you taking a blood thinner (Plavix, Coumadin, Warfarin, Asprin?
- ○ Excessive bleeding from a cut or a dental extraction?
- ○ Have you ever taken Fosomax or Boniva (How long?) ______________
- ○ Do you have anemia or blood problems?
- ○ Tuberculosis?
- ○ Ulcer or colitis?
- ○ Epilepsy?
- ○ Kidney Problems?
- ○ Diabetes?
- ○ Do you have arthritis?
- ○ Radiation Treatments.?
- ○ Malignancies?
- ○ Nervouse disorders, fainting, or dizziness?
- ○ Venereal disease?
- ○ Do you have asthma?
- ○ Hay fever or allergies in general?
- ○ Sinus problems?
- ○ Are you pregnant?
- ○ Cigarette, pipe, or cigar smoking? (How long?) ______________
- ○ Teeth sensitive to cold, heat, sweets, pressure?
- ○ Clenching or grinding of teeth?
- ○ Gums bleed easily?
- ○ Past periodntal treatment?
- ○ Past orthodontic treatment?
- ○ Unfavorable dental experience?

What medicine, pills, or supplements are you taking now? ______________________

____

Are you currently under the care of a physician? If so, why? ______________________

Physician's Name? ______________________ Date of last physical examination: ______________

Chief oral complaint: ______________________

Date of last dental exam: _____/_____/_____ X-Rays: _____/_____/_____ Cleaning: _____/_____/_____

Patient Signature: ______________________ **Date:** ______________

PLEASE CHECK ALL THAT APPLY:

- ○ Toothache
- ○ Broken filling or tooth
- ○ Clench or grind teeth
- ○ Food catches
- ○ Loose teeth
- ○ Floss breaks easily or hurts
- ○ Bite or teeth have shifted
- ○ Often bite cheek
- ○ Frequent dry mouth
- ○ Concerned about breath
- ○ Bad previous dental work
- ○ Gums bleed
- ○ Gums tender
- ○ Growths, Sores
- ○ Cold Sores, fever blisters
- ○ Cracked chapped lips
- ○ Bad taste in mouth
- ○ Sinus problems
- ○ Mouth breath – Difficult breathing through nose
- ○ Dry or strained eyes
- ○ Shoulder, neck or headaches
- ○ Clench or grind teeth
- ○ Jaw joint pain
- ○ Clicking or popping of jaw
- ○ Unable to open mouth wide
- ○ Jaw tires easily
- ○ Hold things between teeth (pipe, pencil, nails, pins)
- ○ Bite fingernails
- ○ Unusual habits with teeth
- ○ Wore braces
- ○ Previous gum treatment
- ○ Previous bite treatment
- ○ Sensitivity to:
  - ○ Cold
  - ○ Hot
  - ○ Sweets
  - ○ Chewing

Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?

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Please rate 1–10 how anxious you are about dental treatment (1 = totally relaxed) ______________

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) ______________

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Do you require antibiotics before dental treatment? ______________

Have you ever had a serious/difficult problem associated with any previous dental work? ______________

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ______________

Your current dental health is: ______________

Would you like whiter teeth? ______________

How many times a week do you floss? ______________

Type of bristles? (please circle) Extra Soft / Soft / Medium / Hard

Do you smoke or use tobacco in any other form? ______________

APPOINTMENT GUIDELINES

We believe in the value of clear communication, as well as mutual understanding and respect prior to treatment rendered. It is our desire to provide high-quality dental care and individual attention for you in a timely manner. Your appointment time has been reserved especially for you and we make every effort to remind patients of their appointment as a courtesy. **Therefore, if you break an appointment without 24 hours' notice, we do not have sufficient amount of time to rebook another patient in need of treatment. With this in mind, a $50.00 fee may be subject to the second missed appointment or cancellation less than 24 hours from you scheduled time. This fee must be paid in full prior to any further appointment(s) scheduled.**

INITIALS ___________

I understand that the 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.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

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Signature Date

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.