

# Cushing Aesthetic Dental

We ask that you fill out the following forms completely so that we may give you the very best and complete dental experience! All information will be held in the strictest confidence.

## PATIENT INFORMATION:

Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Sex: M F Status: Married Single Widowed Minor  
Email: \_\_\_\_\_ Separated Divorced Partnered

How did you hear about us or who referred you: \_\_\_\_\_

Patient's Employer(School): \_\_\_\_\_

Occupation(Grade): \_\_\_\_\_ Employer (Work) Phone: \_\_\_\_\_

Spouse's/Partner's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Spouse's/Partner's Employer: \_\_\_\_\_

## DENTAL INSURANCE:

Suscriber/Employee: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Phone: \_\_\_\_\_ Group #: \_\_\_\_\_

Is patient covered by any additional insurance: Yes No

Suscriber/Employee: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Phone: \_\_\_\_\_ Group #: \_\_\_\_\_

### PLEASE GIVE INSURANCE CARDS TO RECEPTIONIST TO COPY

Assignment and Release: I certify that I, and/or my dependent(s) have insurance coverage with the above noted company(ies) and assign directly to Dr Susan R. Cushing, DMD, all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Cushing and her agents may use my health information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that a deposit is required to reserve my appointment time and that the balance is due when services are rendered. I

accept that past due accounts will be charged 18% interest per year ( 1.5% per month ).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient, Parent, Guardian or Personal Representative

Relationship: \_\_\_\_\_

# Dental History

Former Dentist: \_\_\_\_\_ City/State: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

Reason for today's visit : \_\_\_\_\_

Any Dental anxiety (on a scale of 1-none to 5-high) \_\_\_\_\_

Do you or would you have problems chewing gum ? YES NO

Do you have a problem chewing bagels ? YES NO

Have your teeth changed in the last 5 years ? YES NO

Do you have more than one bite ? YES NO

Do you need to clench or squeeze your teeth together ? YES NO

Do you grind or clench your teeth ? YES NO

Do you wear a Mouthguard? YES NO

Do you sleep restlessly ? YES NO

Have you had Orthodontic treatment (Braces) ? YES NO

Do you like your smile? YES NO

What would you change about your teeth: \_\_\_\_\_

How often do you brush your teeth ? \_\_\_\_\_ How often do you floss ? \_\_\_\_\_

Please place a mark on "YES" or "NO" to indicate if you have any of the following:

Bad breath	YES	NO	Jaw pain or tiredness	YES	NO
Bleeding gums	YES	NO	Lip or cheek biting	YES	NO
Blisters on lips or mouth	YES	NO	Mouth breathing	YES	NO
Burning sensation on tongue	YES	NO	Mouth pain when brushing	YES	NO
Chew on side of mouth	YES	NO	Orthodontic treatment	YES	NO
Cigarette, pipe, cigar or chew	YES	NO	Pain around ear	YES	NO
Clicking or popping	YES	NO	Periodontal (Gum) treatment	YES	NO
Dry mouth	YES	NO	Sensitivity to cold	YES	NO
Fingernail biting	YES	NO	Sensitivity to heat	YES	NO
Food collecting between teeth	YES	NO	Sensitivity to sweets	YES	NO
Foreign object in mouth	YES	NO	Sensitivity when biting	YES	NO
Gums swollen or tender	YES	NO	Sores or growths in mouth	YES	NO

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# MEDICAL HISTORY

Patient's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Although Dental Professionals primarily treat the area in and around the mouth, your mouth is 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 receive. Thank you for answering the following questions.

Are you under a physician's care now? YES NO If YES, please explain: \_\_\_\_\_

Name of physician: \_\_\_\_\_ Phone number: \_\_\_\_\_

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 medication, pills, or drugs including over the counter drugs, herbs or diet supplements? YES NO

If YES, please explain: \_\_\_\_\_

Are you on a special diet? YES NO If yes, please explain: \_\_\_\_\_

Do you use tobacco? YES NO How much and how often: \_\_\_\_\_

Do you use a controlled substance? YES NO If YES, please explain: \_\_\_\_\_

Women: Are you pregnant or trying to get pregnant? YES NO Are you taking oral contraceptives? YES NO Nursing? YES NO

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

If YES, please explain: \_\_\_\_\_

Place a mark on "YES" or "NO" to indicate if you do have, or have ever had, any of the following :

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

Have you ever had any serious illness not listed above? YES NO If YES, please explain: \_\_\_\_\_

Do you have a family history of Heart Disease, Diabetes, Immune Disorders? YES NO If YES, please explain: \_\_\_\_\_

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.

I authorize the diagnosis and treatment of my dental health by means of X-rays, Study models, Photos or other diagnostic aids that seem appropriate by Dr. Cushing and her staff.

SIGNATURE OF PARENT, PATIENT OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_