



**PATIENT INFORMATION**

Today's Date: \_\_\_\_\_

Patient's NAME: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

\_\_\_\_\_ FIRST MI LAST

(If you are completing this form for another person): Your Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Sex: M F Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street city/state zip

Ph (home): \_\_\_\_\_ Ph (work): \_\_\_\_\_ Ph (cell): \_\_\_\_ - \_\_\_\_\_

Best time to call: \_\_\_\_\_ Email: \_\_\_\_\_

Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street city/state zip

**INSURANCE INFORMATION (If applicable or not previously provided)**

Subscriber Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Subscriber: \_\_\_\_\_

**RESPONSIBLE PARTY (Person responsible for account if different than above)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph (home): \_\_\_\_\_

Ph(work): \_\_\_\_\_

Address: \_\_\_\_\_  
Street city/state zip

**EMERGENCY CONTACT**

Whom should we contact? \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Were you referred to our office? By whom: \_\_\_\_\_

*Please turn off cell phones. Thank you.*

**DENTAL AND ORAL HEALTH**

What is the primary reason for your visit today?  
\_\_\_\_\_

Are you currently in pain? Y or N

Describe any previous problems you may have had with past dental treatment or special areas of concern you would like to have addressed by Dr. Bushnell/Dr. Morehouse and his staff.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ How often do you have dental exams? \_\_\_\_\_

When do you usually brush? \_\_\_\_\_ Floss? \_\_\_\_\_

Please indicate any of the following concerns and any previously treated dental conditions:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Teeth that are sensitive:<br>breath  | <input type="checkbox"/> Discomfort in jaw joint (TMJ)    | <input type="checkbox"/> Unpleasant taste/persistent bad       |
| <input type="checkbox"/> Air <input type="checkbox"/> Cold <input type="checkbox"/> Hot <input type="checkbox"/> Biting | <input type="checkbox"/> Difficulty opening or moving jaw | <input type="checkbox"/> Bleeding or sore gums                 |
| <input type="checkbox"/> Broken/Chipped teeth<br>cleanings  | <input type="checkbox"/> Clenching or grinding teeth      | <input type="checkbox"/> Periodontal disease or “deep”         |
| <input type="checkbox"/> Lost/Broken fillings   | <input type="checkbox"/> Orthodontics / “Braces”          | <input type="checkbox"/> Food catching between teeth           |
| <input type="checkbox"/> Missing teeth  | <input type="checkbox"/> Oral/Jaw surgery                 | <input type="checkbox"/> Blisters/Sores in or around the mouth |

# MEDICAL HISTORY

Are you allergic to - or have you had a bad reaction to - any of the following?

- Latex
- Penicillin
- Tetracycline
- Sulfa Drugs
- Aspirin/Ibuprofen
- Codeine
- Dental Anesthetics
- Jewelry/Metal
- Foods: \_\_\_\_\_
- Other: \_\_\_\_\_

Please list any medications you are taking:  
(Or provide a complete list to the receptionist).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do these include:  Blood Thinners  Insulin  
 Bisphosphonate (Osteoporosis  
meds)  Pain Killers  Sedatives  
OTC (over-the-counter) meds:

Vitamins/Supplements:

\_\_\_\_\_

\_\_\_\_\_

What is your preferred pharmacy?

\_\_\_\_\_

How would you rate your current health?

Good  Fair  Poor

Do you smoke or use tobacco? Y or N

Have you abused drugs in the past? Y or N

Do you have a personal physician? Y or N

If so, Physician's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Reason of last visit: \_\_\_\_\_

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

- |                                |                               |
|--------------------------------|-------------------------------|
| Y N...Anemia                   | Y N...Hemophilia              |
| Y N...Arthritis                | Y N...Hepatitis _____         |
| Y N...Artificial Joints/Valves | Y N...High Blood Pressure     |
| Y N...Asthma                   | Y N... Low Blood Pressure     |
| Y N...Back Problems            | Y N...HIV/AIDS                |
| Y N...Breathing Difficulty     | Y N...Kidney disease          |
| Y N...Bruise Easily            | Y N...Liver disease           |
| Y N...Cancer                   | Y N...Migraine/Headaches      |
| Y N...Chemotherapy             | Y N...Mitral Valve Prolapse   |
| Y N...Chest Pain               | Y N...Organ Transplant        |
| Y N...Congenital Heart Defect  | Y N...Pacemaker               |
| Y N...Cosmetic Surgery         | Y N...Psychiatric Problems    |
| Y N...Diabetes: type _____     | Y N...Radiation Therapy       |
| Y N...Dry Mouth                | Y N...Respiratory problems    |
| Y N...Eating Disorder          | Y N...Seizures                |
| Y N...Emphysema                | Y N...Shingles                |
| Y N...Epilepsy                 | Y N...Sinus problems          |
| Y N...Excessive Bleeding       | Y N...STD                     |
| Y N...Fainting/Dizziness       | Y N...Steroid Treatment       |
| Y N...Head Injury              | Y N...Stroke                  |
| Y N...Hearing _____            | Y N...Thyroid or Adrenal Dis. |
|                                | Y N...Tuberculosis TB         |
|                                | Y N...Ulcers                  |

Have you ever experienced prolonged or excessive bleeding?

Y or N

Please list any other serious medical condition: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CONSENT - To the best of my knowledge, all of the preceding information is correct. If there is ever any change to this medical status, this practice will be informed without fail. I understand this information will be held in the strictest confidence and will not be shared with anyone outside the office without written consent that is signed and dated. I do authorize the release of all information necessary to secure the payment of benefits. I hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual. I also authorize the use of anesthesia and/or other medication necessary for dental treatment to be rendered by the dental staff.

## OFFICE USE: UPDATES

Date \_\_\_\_\_ Initials \_\_\_\_\_

Date \_\_\_\_\_ Initials \_\_\_\_\_

Date \_\_\_\_\_ Initials \_\_\_\_\_

Date \_\_\_\_\_ Initials \_\_\_\_\_

Date \_\_\_\_\_ Initials \_\_\_\_\_



## Your Child's Dental History and Habits

Your Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Date \_\_\_\_\_

**Welcome!** So that we may provide your child with the best possible care, please complete both sides of this dental/medical history form. All information is completely confidential. Please be sure to answer individually any yes or no questions.

What is the reason for your visit today? \_\_\_\_\_  
\_\_\_\_\_

Your Child's Previous Dentist: \_\_\_\_\_

Date of your child's last dental visit: \_\_\_\_\_

When does your child brush? \_\_\_\_\_ Do you assist?.....Yes No

Does your child take Fluoride supplements?.....Yes No

Does your child have any dental problems now?.....Yes No If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

Are any of your child's teeth sensitive to:

Hot or Cold?.....Yes No      Sweets?.....Yes No      Biting or Chewing?..... Yes No

Has your child had difficulty with previous dental visits?.....Yes No If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

How do you think your child will handle today's visit?  
\_\_\_\_\_

Does your child have any pain or tenderness in the jaw joint, ear, side of face?.....Yes No

Has your child complained about dental problems?.....Yes No

Do your child's gums bleed or hurt?.....Yes No

Has your child ever worn orthodontic appliances?.....Yes No

Does your child engage in:

Sucking thumb or fingers?.....Yes No

Chewing or biting

fingernails?.....Yes No

Chewing hard objects (e.g.

Biting or sucking lips or cheeks?.....Yes No

pencils)?.....Yes No

Clenching

Grinding teeth?.....Yes No

jaw?.....Yes No

Nursing bottle or pacifier

Mouth breathing?.....Yes No

habits?.....Yes No

Do you have any special concerns about your child's dental health?.....Yes No If yes, please describe: \_\_\_\_\_

# Your Child's Medical History

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Medical Alert \_\_\_\_\_

Who is accompanying this child today? \_\_\_\_\_  
Full Name (If Other Than Parent) Relation to child

Do you have Legal Custody of this child?....Yes No

**Mother's Name:** \_\_\_\_\_  
 \_\_\_\_\_  
(Check if same as child) Address City State Zip  
 \_\_\_\_\_  
Home phone# Work phone# Ext..  
 \_\_\_\_\_  
Mother's Social Sec.# Date of Birth Driver's License  
**Employer:** \_\_\_\_\_  
 \_\_\_\_\_  
Emp. Address City State Zip

**Father's Name:** \_\_\_\_\_  
 \_\_\_\_\_  
(Check if same as child) Address City State Zip  
 \_\_\_\_\_  
Home phone# Work phone# Ext..  
 \_\_\_\_\_  
Father's Social Sec.# Date of Birth Driver's License  
**Employer:** \_\_\_\_\_  
 \_\_\_\_\_  
Emp. Address City State Zip

**Primary Dental Insurance (Or Provide Card)**  
**Co. Name:** \_\_\_\_\_  
 \_\_\_\_\_  
Address City State Zip  
**Insured's ID#** \_\_\_\_\_ **Group#** \_\_\_\_\_  
**Insured's Name:** \_\_\_\_\_

**Secondary Dental Insurance**  
**Co. Name:** \_\_\_\_\_  
 \_\_\_\_\_  
Address City State Zip  
**Insured's ID#** \_\_\_\_\_ **Group#** \_\_\_\_\_  
**Insured's Name:** \_\_\_\_\_

Your Child's Physician: Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is your child taking any medications? (prescription or over-the-counter).....Yes No  
 If yes, please describe \_\_\_\_\_

Have you ever been told your child needs antibiotics or premeds before treatment?.....Yes No

Does your child have any allergic (or adverse) reaction to any medication or other substance?..... Yes No  
 If yes, please describe \_\_\_\_\_

Are your child's immunizations current?.....Yes No

List any Hospitalizations, Surgeries, Serious Illnesses \_\_\_\_\_ When? \_\_\_\_\_



**Indicate which of the conditions your child has now or ever has had:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV positive           | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Lung problem              |
| <input type="checkbox"/> Allergies or Hives          | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Measles/Mumps             |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Mononucleosis             |
| <input type="checkbox"/> Behavioral/Learning problem | <input type="checkbox"/> Hearing problem        | <input type="checkbox"/> Nervous disorder          |
| <input type="checkbox"/> Bleeding disorder           | <input type="checkbox"/> Heart condition        | <input type="checkbox"/> Psychiatric/Psychological |
| <input type="checkbox"/> Brain Injury                | <input type="checkbox"/> Hepatitis _____        | <input type="checkbox"/> Rheumatic/Scarlet fever   |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Hyperactive/ADD        | <input type="checkbox"/> Sickle Cell Anemia        |
| <input type="checkbox"/> Cerebral palsy              | <input type="checkbox"/> Kidney/Liver problems  | <input type="checkbox"/> Stomach problem           |
| <input type="checkbox"/> Chicken pox                 | <input type="checkbox"/> Latex sensitivity      | <input type="checkbox"/> Tonsillitis               |
| <input type="checkbox"/> Cleft Lip/Palate            | <input type="checkbox"/> Leukemia/Anemia        | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Congenital heart disease    |   |  |

I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will inform the office of any change in my child's health or medication.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

## **SOME THINGS YOU SHOULD KNOW ABOUT DENTAL BENEFITS**

We believe that you deserve the best care. That's why we present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of folks. Some have dental benefits, but most don't. If you have dental benefits, congratulations! You are very fortunate. If you don't, we have numerous ways to make any type of dental care affordable for you. Here are some important things you should know if you do have dental benefits...

Your dental benefits are based upon a contract made between your employer and an employee benefits company. If you have any questions regarding your dental benefits please contact your employer or the benefits carrier directly.

Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of \$1,000. You'll be surprised to know that today the average dental benefit plan has a yearly maximum cap of \$1,000. There has been no significant increase in the yearly maximum cap in 50 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It has always been meant to assist you.

Many people receive notification from their insurance company that dental fees are "above usual and customary." A dental benefits company determines their reimbursement level by surveying a geographical area, calculating the average fee, then determines that 80% of the average fee is customary. Included in this survey are discount dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that dental benefit companies define as "higher than usual and customary."

Dental benefit companies do not cover many routine and newer dental services.

Our team members will gladly assist you in filing your claim to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We hope you will choose the best that dentistry has to offer.

## Payment Options

Patient Name: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

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

Total Treatment Estimate: ~ \_\_\_\_\_ – Insurance Estimate: \_\_\_\_\_ Portion Payment: \_\_\_\_\_  
(Treatment List Attached)

1. Payment in Advance:

We are happy to offer a **7%** reduction when payment is made **at least 1-week prior to treatment**.

\$ \_\_\_\_\_  
Discount

\$ \_\_\_\_\_  
Adjusted Total

Must Be Paid By:

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

2. Payment at Each Visit:

We can offer a **5%** reduction when payment is made in cash **at treatment appointment**. This offer is not available with use of a credit card or if patient is covered by insurance. (Fee is already reduced in these instances).

\$ \_\_\_\_\_  
Discount

\$ \_\_\_\_\_  
Adjusted Total

3. Three Equal Monthly Payments:

One-third of the patient's portion of treatment fee must be paid initially. The next month, another third is paid, and the remaining third (remaining balance) is paid the next month. The remaining balance must be guaranteed with a major credit card.

\$ \_\_\_\_\_  
Payment at 1st appointment

\$ \_\_\_\_\_  
Month 2 payment

\$ \_\_\_\_\_  
Month 3 payment

4. Outside Financing:

Total Treatment Fee is budgeted through **Care Credit** or **Citi Health Card**.

- "Same as Cash" Interest-Free Credit Line Monthly Payments (up to 12 months) interest free
- Extended Payment Plan: 18-60 months duration. No down payment. No pre-payment penalty

5. "Lay-Away" Plan:

Treatment commences after comfortable monthly payments are made which equal the estimated patient portion.

I have read and understand the information above and have checked my choice of payment plans. I understand that any insurance estimate is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office.

Patient Signature: \_\_\_\_\_

Approved By: \_\_\_\_\_

*These fees are valid for 90 days.*

**Benjamin D. Bushnell, D.D.S.**

**Douglas A. Morehouse, D.D.S.**

**FINANCIAL RESPONSIBILITY**

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Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life enhancing care. We are always available to answer your questions and/or assist you in any way we can.

All dental services, including emergencies, must be paid in full at the time services are performed unless other arrangements are made.

**For our patients with dental insurance:** We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the carrier and the patient. As such, **we can make no guarantee of estimated coverage or payment.** However, please know that we will do everything possible to see that you receive the full benefits of your policy.

Please be advised that **any remaining balance after insurance has paid will be your responsibility and you will be expected to pay this estimated balance at the time services are performed.** You are ultimately responsible for all charges incurred for dentistry performed upon yourself or your dependents in this dental office. This office cannot render services on the assumption that our charges will be paid by an insurance company. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

I authorize Benjamin D. Bushnell D.D.S. to perform dental procedures on me, my minor children and / or family members. I understand that dental procedures may vary from planned treatment at the decision of the dentist, according to his knowledge or judgment, in order to provide the highest quality of care in the best interest of the patient.

I hereby authorize the release of any information, including any diagnostic records (x-rays, photographs, charting) to my insurance company. I authorize my insurance company to pay directly to Benjamin D. Bushnell D.D.S. any proceeds payable under the terms of my insurance policy. I understand that I am responsible for my dental bills and the balance on my account regardless of my insurance coverage. I understand that I may incur an 18% finance charge if my balance goes beyond 30 days. I understand that I may incur a \$25 charge on returned checks. I understand, in the event that my account is turned over to an outside collection agency that I am responsible for all fees incurred by Benjamin D. Bushnell D.D.S., P.C. as a result of non payment on my account. I hereby authorize the use of the telephone numbers that I have provided for clinical and collective purposes. I have read and understand the financial policy statement provided to me by office staff.

**CANCELLATION POLICY**

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We respect the importance of your time and work very hard to schedule appointments which accommodate the needs of all our patients. In return, we ask that patients make every effort not to change reserved dental appointments. Broken and missed appointments create scheduling problems for other patients as well as the practice.

If emergency circumstances prevent you from keeping an appointment we certainly understand, all we ask is that you call us immediately so we can try to accommodate another patient. We ask you to provide us with a minimum of twenty-four hours notice. Failure to do so may result in a cancellation/missed appointment fee.

We provide as a courtesy, reminder cards that are mailed for dental hygiene appointments. We also make reminder calls to our patients the day prior to an appointment. This effort shows our commitment to all of our patients and the importance of their health.

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I have read and fully understand the above office policies regarding payments and cancellations and accept the terms as they were presented to me.

Print Name \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_