TODAY'S DATE: _____

WHOM MAY WE THANK FOR REFERRING YOU?

_____

Dr. Olivia Rauschenbach DDS LLC

10550 Quivira Road SUITE 210 | Overland Park, KS 66215 | Phone: (913) 492-7822 | Fax: (913) 541-0501

WELCOME TO OUR OFFICE

In order to serve you properly, we need the following information. All information is strictly confidential.

GENERAL

Patient's Name _____ Birthdate _____
(LASt) (FIRSt) (MIDDLE INItIAL) (MONtH/DAY/YEAR)

Preferred Name/Nickname _____

Social Security # _____ Marital Status _____

Address _____
(StREEt) (CItY) (StAtE) (ZIP)

Home Phone ( ) _____ Work Phone ( ) _____

Employer _____ Address _____

Email _____ Cell Phone ( ) _____

Person Responsible for Account _____

Name of Spouse (or Parent) _____

Employer _____ Phone ( ) _____

Person to Contact in Case of Emergency _____

Address _____ Phone ( ) _____

INSURANCE

Please fully complete the information below. Because we cannot change claim information if a claim is rejected, please verify that information is accurate and pertains to dental insurance (not medical). Furnishing a dental insurance claim form at the end of each appointment is helpful but not required. Any balance outstanding to insurance beyond six days is your responsibility for payment, regardless of claim status.

Primary Insurance Company _____ Group # _____

Insurance Company Address _____
(StREEt) (CItY) (StAtE) (ZIP)

Insured Name _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Emplyer _____ Phone ( ) _____

Secondary Insurance Company _____ Group # _____

Insurance Company Address _____
(StREEt) (CItY) (StAtE) (ZIP)

Insured Name _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

FINANCIAL

By signing below I authorize release of any and all necessary information to my insurance provider to generate payment and for this practice to receive payment directly. I understand and agree that I am financially responsible for the balance on my account after 60 days regardless of insurance status. Should this account become delinquent I understand that I am responsible for all finance charges or missed appointment fees that accrue on my account. We will file your dental insurance for you as a courtesy; it is your responsibility to follow up with your dental insurance carrier for claim status and insurance payment in a timely manner.

Any balance you owe is due in full at each appointment. You may pay by cash, check, Mastercard, Discover or Visa.

Signed _____ Date _____
(PAtIENt, OR PARENt IF MINOR)

PATIENT MEDICAL HISTORY

Physician _____Office Phone _____Date of Last Exam _____

YES NO

☐ ☐ 1. Are you under medical treatment now?

☐ ☐ 2. Have you ever been hospitalized for any surgical operation or serious illness?

☐ ☐ 3. Are you taking any medication(s) including non-prescription medicine?

If yes, what medications are you taking? _____
_____
_____
_____
_____
_____

☐ ☐ 4. Do you use tobacco?

☐ ☐ 5. Are you allergic to or have any reactions to the following?

YES NO

☐ ☐ Aspirin
☐ ☐ Local Anesthetics (e.g. novocaine)
☐ ☐ Latex
☐ ☐ Penicillin
☐ ☐ Sulfa
☐ ☐ Other _____

☐ ☐ 6. Women Only

YES NO

☐ ☐ Are you pregnant?
☐ ☐ Are you nursing?
☐ ☐ Are you taking birth control pills?

DO YOU HAVE ANY OF THE FOLLOWING?

YES NO

☐ ☐ Joint Replacement or Implant
☐ ☐ Angina
☐ ☐ Cardiac Pacemaker
☐ ☐ Heart Disease
☐ ☐ Heart Murmur
☐ ☐ Heart Surgery
☐ ☐ Mitral Valve Prolapse
☐ ☐ Stroke
☐ ☐ Anemia
☐ ☐ Arthritis
☐ ☐ Asthma
☐ ☐ Diabetes
☐ ☐ Easily Winded
☐ ☐ Epilepsy
☐ ☐ Convulsions

YES NO

☐ ☐ Fainting
☐ ☐ Seizures
☐ ☐ Frequently tired
☐ ☐ Glaucoma
☐ ☐ Hay Fever
☐ ☐ Alleriges
☐ ☐ High Blood Pressure
☐ ☐ Low Blood Pressure
☐ ☐ Kidney Disease
☐ ☐ Leukemia
☐ ☐ Radiation therapy
☐ ☐ Recent Weight Loss
☐ ☐ Respiratory Problems
☐ ☐ Rheumatic Fever
☐ ☐ Stomach troubles

YES NO

☐ ☐ ulcers
☐ ☐ Swollen Ankles
☐ ☐ thyroid Problem
☐ ☐ Cancer
☐ ☐ Emphysema
☐ ☐ AIDS
☐ ☐ HIV Infection
☐ ☐ Hepatitis
☐ ☐ Jaundice
☐ ☐ Herpes
☐ ☐ Mouth Sores
☐ ☐ Liver Disease
☐ ☐ tuberculosis
☐ ☐ Other _____
_____

PATIENT DENTAL HISTORY

YES NO

☐ ☐ 1. Do your gums bleed while brushing or flossing?
☐ ☐ 2. Are your teeth sensitive to hot or cold liquids/food?
☐ ☐ 3. Are your teeth sensitive to sweet or sour liquids/food?
☐ ☐ 4. Do you feel pain to any of your teeth?
☐ ☐ 5. Do you have sores or lumps in or near your mouth?
☐ ☐ 6. Have you had any head, neck or jaw injuries?
☐ ☐ 7. Have you ever experienced any of the following problems in your jaw?
☐ ☐ a. Clicking?
☐ ☐ b. Pain (joint, ear, side of face)?
☐ ☐ c. Difficulty in opening or closing?
☐ ☐ d. Difficulty in chewing?
☐ ☐ 8. Do you have frequent headaches?
☐ ☐ 9. Do you clench or grind your teeth at night?
☐ ☐ 10. Do you bite your lips or cheeks frequently?
☐ ☐ 11. Have you ever had any difficulty with extractions?
☐ ☐ 12. Have you ever had any prolonged bleeding following extractions?
☐ ☐ 13. Do dental procedures bother you exceedingly?
14. How long has it been since your last dental visit?
_____
15. Primary reason for this appointment? _____
_____

I certify that I have read and that I understand the above information. to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____Date _____

(PATIENT, PARENT OR GUARDIAN)