msd

main street dental
Jodi Rump D.D.S.

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

First Name _____ Middle _____ Last Name _____ Preferred Name (if any) _____

Address _____ City _____ State _____ Zip Code _____

Billing Address (if different) _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Contact preference (phone, email or text) _____

Contact name & number in case of emergency _____ How did you hear about us? _____

Date of Birth (mm/dd/yyyy) ____/____/____ Age _____ Social Security # (For Insurance) _____ Driver's License # _____

~ If you make insurance cards available for us to photo copy you do not need to enter your insurance information ~

Employer of Primary Insurance Holder _____ Employer Phone of Primary Insurance Holder _____

Primary Insurance Company _____ Phone _____

Policy # _____ Group # _____

Employer of Secondary Insurance Holder _____ Employer Phone of Secondary Insurance Holder _____

Secondary Insurance Company _____ Phone _____

Policy # _____ Group # _____

INFORMED CONSENT FOR TREATMENT

I, the undersigned, hereby authorize the Doctor to take radiographs, study models, photographs, records or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent the Doctor to employ any such assistance as he/she deems appropriate under the law. I further authorize the release of diagnosis, radiographs, patient records, treatments or examinations rendered: to my insurance company, consulting professionals and others I approve.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. Reservations require a great deal of setup and preparation tailored to you and your treatment. Last minute cancellations and missed reservations will be charged $50.00 per half hour scheduled. To avoid this charge, contact our office within 24 hours of your reservation. We do understand, on occasion, last minute things occur. If we both take our commitment to each other seriously, these issues are often avoidable. I have also received a copy of the Privacy Policy, Financial Policy, and Appointment Policy.

_____

(Patient or Guardian Signature) Print Name Date

main street dental
Jodi Rump D.D.S.

MEDICAL HEALTH HISTORY

First Name _____ Last Name _____ Name of Personal Physician & Office _____ Office Phone _____

Rate your overall health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent Height _____ Weight _____

Select the following drugs you have used at any time:
☐ Fosamax ☐ Aredia ☐ Zometa ☐ Actonel
☐ Didronel ☐ Boniva ☐ Skelid ☐ Bisphosphonate

For Women
☐ Birth Control or Hormones ☐ Possibly Pregnant
☐ Pregnant - Delivery Date:_____ ☐ Nursing

Jaw Discomfort-TMJ
No Yes
☐ ☐

Please answer YES or NO to the following questions:

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Problems	☐	☐	Intestinal Problems	☐	☐	Physician required premeds _____
☐	☐	Chest pain	☐	☐	Ulcers	☐	☐	Cancer or Tumor
☐	☐	Shortness of breath	☐	☐	Weight gain or loss	☐	☐	Tuberculosis/Respiratory disease _____
☐	☐	Blood pressure problem	☐	☐	Special diet	☐	☐	Do you drink alcohol?
☐	☐	Heart murmur	☐	☐	Constipation/Diarrhea	☐	☐	Do you smoke?
☐	☐	Heart valve problem	☐	☐	Kidney or bladder problems	☐	☐	Use recreational drugs
☐	☐	Taking heart medication	☐	☐	Bone or Joint Problems	☐	☐	History of alcohol or drug abuse
☐	☐	Rheumatic fever	☐	☐	Arthritis	☐	☐	Jaundice or liver trouble
☐	☐	Pacemaker	☐	☐	Back or neck pain	☐	☐	HIV +/AIDS
☐	☐	Artificial heart valve	☐	☐	Joint replacement	☐	☐	Glaucoma
☐	☐	Blood Problems	☐	☐	Diabetes	☐	☐	Narrow angle glaucoma
☐	☐	Frequent nosebleeds	☐	☐	Dry mouth or constantly thirsty	☐	☐	Slow clotting
☐	☐	Abnormal bleeding	☐	☐	Family history of diabetes	☐	☐	Do you wear contact lenses
☐	☐	Blood disease (anemia)	☐	☐	If you have diabetes, is it controlled	☐	☐	Hempohilia
☐	☐	Ever require a blood transfusion			HA-1C Score ____ Date _____	☐	☐	Hepatitis? Type _____
☐	☐	Allergy Problems	☐	☐	Fainting spells, seizures, epilepsy	☐	☐	Fainting spells
☐	☐	Hay fever	☐	☐	Stroke(s)	☐	☐	Herpes or other STD _____
☐	☐	Sinus problems	☐	☐	Frequent or severe headaches	☐	☐	Emphysema
☐	☐	Asthma	☐	☐	Thyroid problems	☐	☐	Lung disease or COPD

Please answer the following - IF NONE, WRITE NONE. Use back of paper or attach list if needed:

Have you ever had surgery? Yes ☐ No ☐ If yes, please list _____

List ALL medications you CURRENTLY take (OTC and Prescription) _____

List ANY medications you've taken in the last year not listed above _____

List ALL allergies (Example: Aspirin, Antibiotics, Latex, Foods) _____

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify Main Street Dental of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold Main Street Dental or its employees liable in the event of death or injury.

(Patient or Guardian Signature) Print Name Date

msd

main street dental
Jodi Rump D.D.S.

DENTAL HEALTH HISTORY

First Name _____ Last Name _____

Rate your dental health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

How do you feel about dental treatment? ☐ Relaxed ☐ A little uneasy ☐ Tense ☐ Anxious ☐ Very Anxious ☐ Major Phobia

Reason for seeking dental care at this time? _____

Do you have any problems, concerns or pain we need to be aware of? _____

How often do you brush & floss? Brush 1 • 2 • 3+ Per: Day / Week / Month / Never Floss 1 • 2 • 3+ Per: Day / Week / Month / Never

Date of last dental visit? _____ Date of last dental x-rays? _____ Previous Dentist _____

If you could change your smile, what would you change? _____

Please answer YES or NO to the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Hot/Cold sensitive teeth	☐	☐	Grinding/Clinching of teeth	☐	☐	Cold Sores/Oral Lesions
☐	☐	Teeth sensitive to sweets	☐	☐	Face/Mouth pain	☐	☐	Catch food between teeth
☐	☐	Sore/Bleeding gums	☐	☐	Clicking/Popping of jaw	☐	☐	Discolored teeth
☐	☐	Periodontal Disease	☐	☐	Difficulty Opening/Chewing	☐	☐	Loose teeth
☐	☐	Missing teeth	☐	☐	Unsightly Spaced teeth	☐	☐	Chipped or broken teeth
☐	☐	Toothaches	☐	☐	Crooked/Tipped teeth	☐	☐	Gag easily
☐	☐	Offensive/Bad Breath	☐	☐	Growth or lesion in your mouth	☐	☐	Wear dentures or partials
☐	☐	Consume Coffee/Tea	☐	☐	Swollen glands	☐	☐	Is your bite uncomfortable or uneven
☐	☐	Sensitive to metals	☐	☐	Broken filling(s)	☐	☐	Dissatisfied with appearance of your teeth
☐	☐	Unfavorable dental experience	☐	☐	Does jaw pain affect daily routine	☐	☐	Other _____

Do you have any disease, condition, or concerns not listed previously that you feel we should know about? _____

_____ ☐ See Attached List

OFFICE USE ONLY