RASMUSSEN
PERIODONTICS AND IMPLANT DENTISTRY

Dr. Rick Rasmussen, DMD, MS
Board Certified Periodontist

MEDICAL/DENTAL HISTORY

Do you have or have you ever had: YES NO

1. Hospitalization for illness or injury _____ ☐ ☐
2. An allergic reaction to
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin ☐ erythromycin
   - ☐ tetracycline ☐ sulfa
   - ☐ local anesthetic ☐ fluoride
   - ☐ metals (nickel, gold, silver, _____)
   - ☐ latex
   - ☐ other _____

Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone Number: _____
Restorative Dentist: _____

3. Are you in good health? . . . . . Yes ☐ No ☐
4. Date of last physical examination _____ Are you currently being treated by a physician? . . . . Yes ☐ No ☐
   Physician Name: _____ Physician Number: _____
5. Are you taking any prescription drugs or medications? . . . . . Yes ☐ No ☐
   If yes, please list _____
6. Are you taking any over-the-counter preparations or medications (example: aspirin, vitamins, supplements)? . . . . . Yes ☐ No ☐
   If yes, please list _____
7. Indicate which of the following you have had or have at the present:

Heart disease or attack	Yes ☐	No ☐	Allergies or hives	Yes ☐	No ☐	Anemia	Yes ☐	No ☐
High blood pressure	Yes ☐	No ☐	Sinus trouble	Yes ☐	No ☐	Prolonged bleeding	Yes ☐	No ☐
Angina	Yes ☐	No ☐	Thyroid disease	Yes ☐	No ☐	Hemophilia	Yes ☐	No ☐
Congenital heart lesions	Yes ☐	No ☐	Liver disorder	Yes ☐	No ☐	Immune system disorder	Yes ☐	No ☐
Artificial heart valve	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐	AIDS/HIV positive	Yes ☐	No ☐
Heart pacemaker	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Fainting or dizziness	Yes ☐	No ☐
Heart surgery	Yes ☐	No ☐	Hemoglobin A1c.	_____		Epilepsy or seizures	Yes ☐	No ☐
Hip/Knee replacement	Yes ☐	No ☐	Hypoglycemia	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Other joint replacement	Yes ☐	No ☐	Arthritis or rheumatism	Yes ☐	No ☐	Chemotherapy	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Osteoporosis	Yes ☐	No ☐	Radiation treatment	Yes ☐	No ☐
Kidney disorder	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐	Mental disorder	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	Cold sores/fever blisters	Yes ☐	No ☐	Anxiety	Yes ☐	No ☐
Emphysema	Yes ☐	No ☐	Venereal disease	Yes ☐	No ☐	Drug addiction	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Blood disease/disorder	Yes ☐	No ☐	Alcohol addiction	Yes ☐	No ☐

8. Do you have any disease, condition, or problem not listed? . . . . . Yes ☐ No ☐
   If yes, please explain _____
9. Do you currently or have you in the past taken Fosamax, Actonel, Boniva, Prolia or Reclast for osteoporosis/osteopenia or were you treated with the medications Zometa or Aredis for chemotherapy? . . . . . Yes ☐ No ☐
10. Do you currently smoke or use smokeless tobacco? . . . . . Yes ☐ No ☐
11. Have you previously smoked or used smokeless tobacco? . . . . . Yes ☐ No ☐
12. Date of last dental visit . . . . . _____
13. Have you had any problems associated with previous dental treatment? . . . . . Yes ☐ No ☐
14. Have you ever had periodontal treatment? . . . . . Yes ☐ No ☐
15. Have you ever worn braces? . . . . . Yes ☐ No ☐
16. Do you clench or grind your teeth? . . . . . Yes ☐ No ☐
17. Do you experience pain in your jaw joints or facial muscles? . . . . . Yes ☐ No ☐
18. Do you wear any removable dental appliances? . . . . . Yes ☐ No ☐
19. Do you have any specific questions or concerns about your oral health? . . . . . Yes ☐ No ☐
    If yes, please explain _____

WOMEN

20. Are you pregnant? . . . . . Yes ☐ No ☐
21. Are you taking birth control pills? . . . . . Yes ☐ No ☐

SIGNATURE - PATIENT/GUARDIAN	DATE
SIGNATURE - DOCTOR	DATE

RASMUSSEN
PERIODONTICS AND IMPLANT DENTISTRY

Dr. Rick Rasmussen, DMD, MS
Board Certified Periodontist

PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST FIRST MI	DATE OF BIRTH	SEX	SSN

PREFER TO BE CALLED	HOME PHONE	CELL PHONE

PATIENT'S ADDRESS STREET APT # CITY STATE ZIP/POSTAL CODE	E-MAIL

MARITAL STATUS ☐S ☐M ☐W ☐D ☐UNDER AGE 18	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET APT # CITY STATE ZIP/POSTAL CODE	WORK PHONE

SPOUSE/GUARDIAN LAST FIRST MI	SPOUSE/GUARDIAN EMPLOYER	OCCUPATION

SPOUSE'S WORK ADDRESS STREET APT # CITY STATE ZIP/POSTAL CODE	WORK PHONE

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP

HOME PHONE	WORK PHONE	CELL PHONE

Methods of Communication

Unless you indicate a preference to **not** be contacted by a method, our of ice utilizes multiple methods of communication with our patients.

☐ _____ initials

I provide Rasmussen Periodontics and Implant Dentistry and their staff consent to discuss limited Personal Health Information with anyone who transports me to and from an appointment when I am sedated. Examples might include how your treatment went or instructions for any post-treatment care.

RASMUSSEN
PERIODONTICS AND IMPLANT DENTISTRY

Dr. Rick Rasmussen, DMD, MS
Board Certified Periodontist

PLEASE PRINT

DENTAL INSURANCE & FINANCIAL INFORMATION

INSURANCE COVERAGE ☐YES ☐NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐SELF ☐SPOUSE ☐DEPENDENT	SUBSCRIBER'S BIRTH DATE	SSN
GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER'S ADDRESS

SECONDARY COVERAGE ☐YES ☐NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐SELF ☐SPOUSE ☐DEPENDENT	SUBSCRIBER'S BIRTH DATE	SSN
GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER'S ADDRESS

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers	☐	☐	1.
Insurance Companies	☐	☐	2.

NOTICE OF PRIVACY PRACTICES

☐ _____ I have received a copy of the Notice of Privacy Practices of Rasmussen Periodontics and Implant Dentistry. I hereby authorize, as indicated by my initials, Rasmussen Periodontics and Implant Dentistry to use and disclose my protected health information for any necessary clinical, inancial, and insurance purpose, as authorized in the patient consent form.

ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental heath care information in connection with any insurance claim for such care, (3) my dentist to use my dental records in any professional manner that he/she so determines, (4) the making of videotapes, photographs, and x-rays of the dental treatment that I receive before, during and after such treatment (collectively "My Images"), and (5) my dentist to use My Images in scientific papers, demonstrations and/or presentations without compensation to me. If I am signing this form as the guardian of a patient then the above authorization is on behalf of such patient.

I acknowledge and agree that if certain costs of my dental care are not covered by insurance, I am financially responsible and obligated to pay my dentist such uninsured cost in accordance with the payment terms and policies of my dentist. If I am signing this form as the guardian of the dentist's patient, the dentist agrees that my signature does not make me personally liable for the payment of any uninsured costs.

Finally, by signing below I acknowledge my understanding of the risks and limitations involved with the dental treatment that I am to receive or that the patient is to receive if I am signing as such patient's guardian.

SIGNATURE - PATIENT/GUARDIAN	DATE
WITNESS SIGNATURE	DATE

RASMUSSEN
PERIODONTICS AND IMPLANT DENTISTRY

Dr. Rick Rasmussen, DMD, MS
Board Certified Periodontist

Name:_____ Date:_____

Medication: _____

Purpose: _____ Prescribed by: _____

Medication: _____

Purpose: _____ Prescribed by: _____

Medication: _____

Purpose: _____ Prescribed by: _____

Medication: _____

Purpose: _____ Prescribed by: _____

Supplement: _____

Purpose: _____ Prescribed by: _____

Supplement: _____

Purpose: _____ Prescribed by: _____

Supplement: _____

Purpose: _____ Prescribed by: _____

NOTES: _____

_____

_____

_____

_____

_____