SETH RUSH, DDS, MS

PERIODONTICS & DENTAL IMPLANTS

9249 Ward Parkway, Kansas City MO 64114

TEL: (816) 444-8822 | Fax: (816) 444-0492

Patient Information

DATE _____

NAME _____ DATE OF BIRTH _____ AGE _____

S.S.# _____ SEX: M F MARITAL STATUS: S M D W

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE (_____) _____ BUS.PHONE (_____) _____ CELL PHONE (_____) _____

EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

SPOUSE'S NAME _____ S.S. # _____

SPOUSE'S DATE OF BIRTH _____ SPOUSE'S EMPLOYER _____

PERSON RESPONSIBLE FOR ACCOUNT _____

DENTAL INSURANCE COMPANY _____

REFERRED BY _____

PRESENT DENTIST _____ DATE OF LAST VISIT _____

EMERGENCY CONTACT _____ PHONE (_____) _____ RELATION _____

Would you like to receive appointment reminders by email?

If so, please provide your email address: _____

Dental History

Reason for today's visit _____

_____

_____

_____

_____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chewing on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Phone _____ Last Visit _____

Specialist's Name _____ Phone _____ Last Visit _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

Please circle either Yes or No to indicate whether you have had or are experiencing any of the following:

Yes No Anxiety/Depression/Psychiatric Care
Yes No Are you taking medication for anxiety/depression?

Yes No Arthritis
Yes No Osteoarthritis
Yes No Rheumatoid Arthritis

Yes No Artificial Joints

Yes No Blood Disorder
If so, what? _____
(Ex: Anemia, Factor V, Von Willebrand, etc.)

Blood Pressure
Yes No High
Yes No Low

Yes No Are you taking a Blood Thinner?

Yes No Cancer
Type of cancer _____
Yes No Undergoing chemo/radiation?

Yes No Chemical Dependency
Yes No Are you undergoing treatment?

Yes No Cholesterol (elevated)

Yes No Diabetes
What is your A1c value? _____

Yes No Glaucoma

Heart Condition
Yes No Angina
Yes No Atrial Fibrillation
Yes No Artificial Heart Valve
Yes No Coronary Artery Disease
Yes No Damage from Rheumatic/Scarlet Fever
Yes No Heart Attack/Myocardial Infarction
Yes No Mitral Valve Prolapse
Yes No Pacemaker

Yes No Herpes

Yes No HIV Positive
What is your viral load _____
What is your CD4 count _____

Yes No Jaundice/Liver Condition
Hepatitis A B C

Yes No Kidney Disease
Yes No Are you on Dialysis?

Yes No Are you taking Methotrexate (Otrexup/Rasuvo)
If so, why are you taking it?
_____

Yes No Neurologic Disorder
Condition _____

Yes No Osteopenia

Yes No Osteoporosis
Yes No Do you take a pill medication for osteoporosis?
Yes No Are you receiving infusions for osteoporosis?

Respiratory Condition
Yes No Asthma
Yes No COPD
Yes No Tuberculosis

Yes No Sleep Apnea
Yes No Do you use a Cpap or other sleep appliance?

Yes No Former Smoker

Yes No Current Smoker (cigarettes, cigars, marijuana, e-cig/vaping, etc.)
If so, which products do you use?
_____

Yes No Do you use chewing tobacco/other smokeless products?

Yes No Have you had long-term steroid use for a heart or inflammatory condition, etc.?

Yes No Stroke
If so, when? _____

Yes No Thyroid Problems

Yes No Venereal Disease

Height _____ **Weight** _____

Women
Yes No Pregnant
Due Date _____
Yes No Nursing

☐ No Known Drug Allergies

ALLERGIES ***(Check all applicable)***

☐ Aspirin
☐ Benzodiazepines
☐ Codeine
☐ Iodine
☐ Hydrocodone
☐ Latex
☐ Local Anesthetic
☐ NSAIDS
☐ Penicillin/Amoxicillin
☐ Sulfa Drugs
☐ Other _____

PHARMACY (Location &/or Phone): _____

MEDICATIONS: _____

_____

_____

_____

_____

OFFICE USE ONLY: ASA CLASS I II III IV DR/HYG: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

**Name: _____

**Address: _____

**Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Business Manager**

Telephone: **(816) 444-8822**

E-mail: **admin@rushperio.com**

Address: **9249 Ward Parkway Kansas City, Missouri 64114**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

**Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

**_____
{Please Print Name}

**_____
{Signature}

**_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.35 for each page of paper, $10 per page of x-rays and $15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Person: **Business Manager**

Telephone: **(816) 444-8822**

E-mail: **admin@rushperio.com**

Address: **9249 Ward Parkway Kansas City, Missouri 64114**