

River Town Dental

Welcome! Thank you for selecting our dental health care team. We will strive to offer you the best quality care in a compassionate environment.

Patient Information (Confidential)

Last Name _____ First Name _____
Middle Name _____ Prefix _____ Preferred Name _____
Date of Birth _____ Social Security No. _____
 Minor Single Married Divorced Widowed Gender: Male Female
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ E-Mail _____
Whom may we thank for referring you _____

Responsible Party

Same as patient
Name of Person Responsible for this account _____ Gender: Male Female
Date of Birth _____ Social Security No. _____
Relationship to Patient _____ Is this person a patient in our office? _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ E-Mail _____

Insurance Subscriber Information

Name of subscriber _____ Gender Male Female
Insurance company _____ Group # _____
Policy # _____ Subscriber's Social Security No. _____
Subscriber's Date of Birth _____ Employer Name _____ Phone _____
Patient's Relationship to subscriber: Self Spouse Child/Stepchild

Secondary Insurance: If you have coverage from multiple insurance plans please advise us and present cards for photocopies.

Name of subscriber _____ Gender Male Female
Insurance company _____ Group # _____
Policy # _____ Subscriber's Social Security No. _____
Subscriber's Date of Birth _____ Employer Name _____ Phone _____
Patient's Relationship to subscriber: Self Spouse Child/Stepchild

The information on this page is correct to the best of my knowledge. I authorize the dentist to release any information including diagnosis and the records of treatment and examination rendered to me or my child during the period of such dental care to third party payers and or health practitioners. I authorize and request my insurance company pay directly to this dental office. I understand that my dental insurance may pay less than the actual cost of care and agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that if I am delinquent on my account I am responsible for any finance charges that may be assessed and should I default on payment of my account and collection agency services are required all cost of collection including attorney fees will be added to the balance of my account.

Signature of Patient (or guardian) _____ Date _____

River Town Dental

Medical and Dental History

Patient Name _____ DOB _____ Height _____ Weight _____

Medical History

Physician _____ Phone _____ Last Visit _____

Yes No Are you under a physician's care now? If yes, Why? _____

Physicians Name _____ Phone _____

Yes No Have you ever been hospitalized or had a major operation? What? _____

Yes No Are you taking any medications? Please list _____

Yes No Are you allergic to any medications or substances?

Acrylic Aspirin Codeine Latex Local Anesthetic Metal Penicillin other _____

Do you have now or have you ever had any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joint | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone Density Meds. Use | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis A B C | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Endocarditis | <input type="checkbox"/> Yes <input type="checkbox"/> No HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had any other serious illness not listed? _____ | | |

Women are you: Pregnant If Pregnant, due date: _____ Nursing Taking Birth Control

Emergency contact: _____

Dental History

Previous Dentist _____ Date of Last Visit _____

Primary Reason for today's appointment _____

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had problems with previous dental treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you unsatisfied with the appearance of your teeth? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you apprehensive about dental care? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you clench or grind your teeth? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do your gums bleed when brushing or flossing? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience jaw pain or joint clicking? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use any tobacco products? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had orthodontic treatment? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you noticed sores in your mouth? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been treated for gum disease? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are your teeth sensitive to hot, cold or sweets? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any head, neck or jaw injuries? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have dental implants? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had excessive bleeding after extractions? |

To the best of my knowledge all of the preceding answers are correct. I understand that providing incorrect information can be dangerous to my health. If I have any changes in my health status or medication I shall inform the dentist and staff at the next appointment.

Signature of Patient (or guardian) _____ Date _____