River Ridge Dental

General Dentistry including Orthodontics

Patient Information

Name _____ Social Security # _____
(First) (Initial) (Last)

If Minor, Parents Name _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email Address _____

Sex: Male Female Age _____ Birthdate _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Seperated ❑ Domestic Partner

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

How do you prefer to be contacted regarding future appointments: Home # Cell # Email

Whom shall we contact in case of emergency _____ Phone: _____

Whom may we thank for referring you _____

■ Primary Insurance ■

Person Responsible for Account _____

Relation to Patient _____ Birthdate _____ Social Security # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Dental Insurance Company _____ Phone _____

Group # _____ Subscriber ID _____

Names of other dependents under this plan _____

■ Secondary Insurance ■

Person Responsible for Account _____

Relation to Patient _____ Birthdate _____ Social Security # _____

Address (if different from patient) _____ Home Phone: _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Dental Insurance Company _____ Phone _____

Group # _____ Subscriber ID _____

Names of other dependents under this plan _____

■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to River Ridge Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

River Ridge Dental

Dental History

What brings you to our office today? _____

Previous dental office _____ Date of last dental visit _____

Address _____ Phone _____

Circle if you have had problems with any of the following:

Bad Breath	Bleeding Gums	Sensitivity to cold
Sensitivity to hot	Periodontal treatment	Sores in mouth
Food collection between teeth	Grinding or clenching teeth	Sensitivity to sweets
Clicking or popping in jaw	Loose teeth or broken fillings	Sensitivity when biting

How often do you brush? _____ Floss? _____

How happy are you wih the appearance of your teeth?

Why did you leave your previous dentist? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

_____

How can we accommodate you better during your dental visit? _____

Here at River Ridge Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Traditional Orthodontics (Brackets)	Veneers/Lumineers	Invisalign
Sealants	Smile Makeover	Bonding
Partials/Dentures	Crown and Bridge	Implant Crowns
	Night/Sport Guards	

General Consent to Perform Dentistry

I hereby authorize any of the doctors at this facility and dental auxilliaries to proceed with and perform the dental procedures and treatments as have been explained to me. I understand that treatment can only be estimated and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment.

Signature of patient, parent if minor _____ **Date** _____

River Ridge Dental

Medical History

Physician's Name _____ Physician's Phone _____

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

Have you ever been hospitalized or had a major operation? Yes No If yes, for what? _____

Have you ever had a serious head or neck injury? Yes No

Do you take, or have you taken bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Didronel, Boniva)? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No If yes, what type and how often? _____

Do you use controlled substances? Yes No

Women: Are you pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Have you ever been required to take antibiotic premedication prior to dental procedures? Yes No

Do you have, or have you had, any of the following? Please circle all that apply.

Acid Reflux	Chemotherapy	Frequent Diarrhea	Irregular Heartbeat	Scarlet Fever
AIDS/HIV positive	Chest Pains	Frequent Headaches	Jaundice	Shingles
Alzheimer's Disease	Cold Sores	Genital Herpes	Kidney Problems	Sickle Cell Disease
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Leukemia	Sinus Trouble
Anemia	Convulsions	Hay fever	Liver Disease	Stroke
Angina	Cortisone Medication	Heart Attack / Failure	Low Blood Pressure	Swelling of limbs
Arthritis/Gout	Diabetes	Heart Murmur	Lung Disease	Thyroid disease
Artificial Heart Valve	Drug Addiction	Heart Pace Maker	Mitral Valve Prolapse	Tonsillitis
Artificial Joint	Easily Winded	Heart Trouble / Disease	Parathyroid Disease	Tuberculosis
Asthma	Emphysema	Hemophillia	Psychiatric Care	Tumors or Growths
Blood disease	Epilepsy or seizures	Hepatitis A	Radiation Treatments	Ulcers
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Recent Weight Loss	
Breathing Problem	Excessive Thirst	High Blood Pressure	Renal Dialysis	
Bruise Easily	Fainting Spells/Dizziness	Hives or Rash	Rheumatic Fever	
Cancer	Frequent Cough	Hypoglycemia	Rheumatism	

Have you ever had any serious illness not listed above? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other _____

Are you currently taking any medications, vitamins or supplements? If yes, please list all and reason for taking:

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of patient, parent or guardian _____ Date _____