Riverton Heights DENTAL CARE

Patient Registration

First name: _____ Last name: _____ Patient is: Responsible party ☐ Child ☐

Address: _____ City: _____ State/Zip: _____ Who can we thank for your referral?

Home phone: ( ) _____ Work phone: ( ) _____ Cell #: ( ) _____ Advertisement ☐ Location ☐ A current patient: _____

Sex: Male ☐ Female ☐ Birth Date: _____ Age: _____ Marital Status: Single ☐ Married ☐ Divorced ☐

Social security number: _____ Drivers license number/state: _____

Employer: _____ Address: _____

E-mail: _____ Emergency contact: _____ Relation: _____ Phone: _____

Responsible Party (Guardian of patient, if patient is under 18 years old)

First name: _____ Last name: _____ Home phone: ( ) _____

Address: _____ City: _____ State/Zip: _____ Work phone: ( ) _____ Cell #: ( ) _____

Sex: Male ☐ Female ☐ Birth Date: _____ Age: _____ Marital Status: Single ☐ Married ☐ Divorced ☐

Social security number: _____ Drivers license number/state: _____

Employer: _____ Address: _____

Primary Insurance: _____

Address: _____

Phone: _____

Name of insured: _____

Social/ID #_____

Relationship to patient: _____

Secondary: _____

Address: _____

Phone: _____

Name of insured: _____

Social/ID# _____

Relationship to patient: _____

Authorization

I authorize my insurance company to pay to Riverton Heights all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submission. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that Riverton Heights cannot render services on the assumption that any of the charges will be paid by an insurance company. I understand that I am financially responsible for all charges whether paid by my insurance or not. I understand that if I do not pay my bill collection action will be taken and I will be responsible for paying any collection and attorney fees; after 90 days interest will also accrue. There will be a $35.00 charge for any missed or canceled appointments unless 24 hour notice is given prior to missing/canceling your appointment.

Signature: _____ **Date:** _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

MEDICAL INFORMATION

1. General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor — Date of last physical exam _____
2. Name & address of your physician _____
3. Are you now under the care of a physician? ☐ Yes ☐ No
4. Are you taking any drugs or medications? ☐ Yes ☐ No
   Please list _____
5. What drugs/medications are you allergic or sensitive to?
6. Do you have any disease, problem, or condition that we should know about? _____
7. Have you ever had antibiotic or other pre-medication before dental treatment? _____
8. Do you have any type of prosthetic replacements such as valves, joints, pacemaker? _____
9. Do you smoke or use tobacco products? ☐ Yes ☐ No
10. WOMEN: Are you, or might you be pregnant? ☐ Yes ☐ No
    If yes, due date? _____

11. Do you have any of the following? (Please circle)

Rheumatic Fever	Respiratory Disease
Heart Surgery	Sinus Trouble
Heart Murmur or Aliments	Asthma or Allergies
Diabetes, Anemia	Fainting Spells
High Blood Pressure	Seizures or Epilepsy
Excessive Bleeding	Kidney Disease
Stroke	AIDS or Test Positive
Herpes	Blood Transfusions
Stomach Ulcers	Arthritis

Metal Sensitivity Latex Allergy Cancer

Other _____

CHANGES	DATE	SIGNATURE
CHANGES	DATE	SIGNATURE

DENTAL INFORMATION

1. Are you having dental discomfort today? ☐ Yes ☐ No
2. What treatment would you like today? _____
3. Are you missing any teeth other than wisdom teeth or Orthodontic extractions? ☐ Yes ☐ No
   Have they been replaced? ☐ Yes ☐ No
4. Do your gums bleed when you brush or floss? ☐ Yes ☐ No
5. Are you concerned about gum disease? ☐ Yes ☐ No
6. Do you have any concerns about the appearance of your teeth? ☐ Yes ☐ No
7. Does it hurt to bite or chew? ☐ Yes ☐ No
8. Does any type of dental treatment make you nervous?
   Please describe _____
9. Do you clench or grind your teeth? ☐ Yes ☐ No
   Do you wear a night guard or splint? ☐ Yes ☐ No
10. How do you feel about the overall condition of your teeth & mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
11. Name of your previous dentist: _____
    City _____ State _____
12. Reason for changing _____
13. How long since your last dental visit and what type of treatment was done? _____
14. Have you ever had a problem with:
    - Local Anesthetic? ☐ Yes ☐ No
    - Previous dental treatment? ☐ Yes ☐ No
    - Nitrous Oxide sedation? ☐ Yes ☐ No
    - Cleaning or periodontal therapy? ☐ Yes ☐ No
15. When was your last cleaning or periodontal therapy?
18. The most important concerns regarding my dental treatment are: _____
19. What factors are most important for your satisfaction with our office? _____
20. Do you have any additional concerns or comments?

CONSENT FOR PATIENT

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or if my medications change, I will accept responsibility to inform the doctor and other appropriate staff members at my next appointment. I hereby grant authority to the dentist or appropriate staff members in charge of the care of the patient whose name appears on this form to administer anesthetics, analgesics, sedatives, nitrous oxide sedation as may be advised for dental treatment. In addition, I give permission for the performance of such procedures and operation as may be recommended in the diagnosis and treatment of this patient. Should I fail to understand the purpose, procedures, or risks of any treatment to be performed, I will request clarification to my satisfaction. All treatment and services are rendered to the patient and accepted under the terms and conditions printed on the reverse side of this form.

SIGNED _____ DATE _____

RELATIONSHIP TO PATIENT _____

PLEASE COMPLETE OTHER SIDE