RIVER STREET FAMILY DENTAL

PATIENT NAME: SEX: DATE OF BIRTH: S.S. #

Telephone (◯Mobile ◯ Work ◯Home)

Email:

ADDRESS: APT/UNIT NO: CITY: STATE: ZIPCODE:

HOW DID YOU HEAR ABOUT OUR PRACTICE?

◯ Mail ◯Newspaper Advertisement ◯Radio Advertisement ◯Internet Search/Web site ◯ Friends/Family ◯ Other

INSURANCE

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Subscriber Name_____ Subscriber ID_____ Date of Birth _____ Relationship to Subscriber Self◯ Spouse◯ Child Other◯ Employer Name _____ Employer Phone_____ Insurance Company_____ Insurance Company_____ Insurance Phone_____	Subscriber Name_____ Subscriber ID_____ Date of Birth _____ Relationship to Subscriber Self◯ Spouse◯ Child Other◯ Employer Name _____ Employer Phone_____ Insurance Company_____ Insurance Company_____ Insurance Phone_____

RESPONSIBLE PARTY (If minor)

PATIENT NAME: SEX: DATE OF BIRTH: S.S. #

Telephone (◯Mobile ◯ Work ◯Home)

Email

ADDRESS: APT/UNIT NO: CITY: STATE: ZIPCODE:

EMERGENCY CONTACT

CONTACT NAME:

Telephone (◯Mobile ◯ Work ◯Home) _____

AUTHORIZATION I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time.

RIVER STREET FAMILY DENTAL

FEMALES ONLY:

ARE YOU PREGNANT OR TRYING TO GET PREGNANT? **IF SO, DUE DATE:** **ARE YOU NURSING?**

NAME OF OB/GYN DR: **PHONE NO:** **ARE YOU TAKING ORAL CONTRACEPTIVES?**

LIST ANY MEDICATIONS, REASON, DOSEAGE& FREQUENCY (USE SEPARATE PAGE IF TOO MANY TO LIST);

HAVE YOU HAD MAJOR SURGERY OR BEEN HOSPITALIZED IN PAST FIVE YEARS? **REASON/DATE:**

HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY?

ARE YOU UNDER A PHYSICIAN'S CARE NOW: **IF SO, PLEASE EXPLAIN:**

PHYSICIAN'S NAME/PHONE NUMBER: **DATE OF LAST PHYSICAL EXAM:**

Are you allergic to any of the following? **ASPIRIN** ◯ **PENICILLIN** ◯ **CODEINE** ◯ **LATEX** ◯ **SULFA DRUGS** ◯ **LOCAL ANESTHESIA** ◯ **ACRYLIC** ◯

FOOD/OTHER ALLERGY: <explain>

Do you currently have, or have ever had, any of the following? **Does you use tobacco products? □Yes □No**

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV POSITIVE	□	□	CORISONE MEDICINE	□	□	HEMOPHELIA	□	□	RADIATION TREATMENTS	□	□
ALZHEIMER'S	□	□	DIABETES	□	□	HEPATITIS A	□	□	RECENT WEIGHT LOSS	□	□
ANAPHYLAX	□	□	DRUG ADDICTION	□	□	HEPATITIS B or C	□	□	RENAL DIALYSIS	□	□
ANEMIA	□	□	EASILY WINDED	□	□	HERPES	□	□	RHEUMATIC FEVER	□	□
ANGINA	□	□	EMPHYSEMA	□	□	HIGH BLOOD PRESSURE	□	□	RHEUMATISM	□	□
ARTHRITIS/GOUT	□	□	EPILEPSY OR SEIZURES	□	□	HIGH CHOLESTEROL	□	□	SCARLET FEVER	□	□
ART.HEART VALVE	□	□	EXCESSIVE BLEEDING	□	□	HIVES OR RASH	□	□	SHINGLES	□	□
ARTIFICIAL JOINT	□	□	EXCESSIVE THIRST	□	□	HYPOGLYCEMIA	□	□	SICKLE CELL DISEASE	□	□
ASTHMA	□	□	FAINTING /DIZZINESS	□	□	IRREGULAR HEARTBEAT	□	□	SINUS TROUBLE	□	□
BLOOD DISEASE	□	□	FREQUENT COUGH	□	□	KIDNEY PROBLEMS	□	□	SPINA BIFADA	□	□
BLOOD TRANS	□	□	FREQUENT DIARRHEA	□	□	LEUKEMIA	□	□	STOMACH/INTEST DISEASE	□	□
BREATHING PROBLEMS	□	□	FREQUENT HEADACHE	□	□	LIVER DISEASE	□	□	STROKE	□	□
BRUISE EASILY	□	□	GENITAL HERPES	□	□	LOW BLOOD PRESSURE	□	□	SWELLING OF LIMBS	□	□
CANCER	□	□	GLAUCOMA	□	□	LUNG DISEASE	□	□	THYROID DISEASE	□	□
CHEMOTHERAPY	□	□	HAY FEVER	□	□	MITRAL VALVE PROL	□	□	TONSILLITIS	□	□
CHEST PAINS	□	□	HEART ATTACK/FAILURE	□	□	OSTEOPOROSIS	□	□	TUBERCULOSIS	□	□
COLD SORE/FEVER BLISTERS	□	□	HEART MURMUR	□	□	PAIN IN JAW JOINTS	□	□	TUMORS OR GROWTHS	□	□
CONG.HEART DISORDER	□	□	HEART PACEMAKER	□	□	PARATHYROID DISEASE	□	□	ULCERS	□	□
CONVULSIONS	□	□	HEART TROUBLE/DISEASE	□	□	PSYCHIATRIC CARE	□	□	VENEREAL DISEASE	□	□
									YELLOW JAUNDICE	□	□

Have you ever had or have any serious illness or conditions not listed above? □Yes □No

If "yes", please list:

ADDITIONAL INFORMATION/COMMENTS:

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 HEALTH: IT IS MY RESPONSIBLITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

SIGNATURE OF PATIENT, PARENT/GUARDIAN: **DATE:**