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RIVERSIDE DENTAL CARE

Family and Cosmetic Dentistry

NEW PATIENT INFORMATION

Name (first, middle, last) _____ Date _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Gender _____ Age _____ Social Security # _____

Phone _____ Email _____ Occupation _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency contact and phone number _____

How did you learn about us? _____

Responsible Party

☐ Self

If not self, please provide: Name _____ Relationship to patient _____

Address _____ Phone number _____

Dental Insurance

Subscriber's Name _____ Subscriber's Birthdate _____

Subscriber Social Security # _____ Relationship to Subsciber _____

Insurance Company _____ Phone _____

ID # _____ Group # _____

Insurance Company Address _____

Is this Insurance offered by Employer ☐ Yes ☐ No If so, Employer's Name _____

Secondary Dental Insurance

Subscriber's Name _____ Subscriber's Birthdate _____

Subscriber Social Security # _____ Relationship to Subsciber _____

Insurance Company _____ Phone _____

ID # _____ Group # _____

Ins. Company Address _____

Is this Insurance offered by Employer ☐ Yes ☐ No If so, Employer's Name _____

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1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostics as deemed appropriate by doctor to make a thorough diagnosis of my dental needs

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care

3. I agree to the use of anesthetics as necessary for my dental treatment. I fully understand that using anesthetic agents embodies certain risks and I understand that I can ask for a complete recital of any possible complications.

4. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

Signature _____

Name _____ Date _____

Name: _____

Dental History

Reason for today's visit _____

Date of last dental visit _____ What was done then? _____

Previous Dentist Name and Location _____

Have you had a complete series of dental films (x-rays) taken? _____

If so, when & where? _____

Please mark your Dental Concerns.

- ☐ Cavities
- ☐ Toothache
- ☐ Sensitive Teeth
- ☐ Infection
- ☐ Pain in Jaw
- ☐ Tooth wear
- ☐ Bleeding Gums
- ☐ Esthetics
- ☐ Bad Breath
- ☐ Dry Mouth
- ☐ Loose teeth
- ☐ Other _____

Have you every had periodontal/gum treatment? If so, when? _____

If you could change anything about your smile, what would you change? _____

Health and illness History

Physician's name and phone # _____

Date of last physical exam _____

Do you smoke, vape, or use another type of tobacco? _____ If yes, what type/frequency? _____

Have you ever been told to take antibiotics or pre-medication before seeing a dentist? _____

Have you ever been hospitalized for any surgical operation or serious illness? _____

Please explain _____

Have you had any abnormal bleeding/do you bruise easily? _____

List all medications currently taking _____

_____

_____

_____

Are you **allergic** to or have you had reactions to:

- [ ] Aspirin
- [ ] Codeine
- [ ] Dental anesthetics
- [ ] Erythromycin
- [ ] Jewelry
- [ ] Latex
- [ ] Metals
- [ ] Penicillin
- [ ] Tetracycline
- [ ] Other _____

Please check any conditons that apply

- [ ] Rheumatic Fever
- [ ] Artificial heart valve
- [ ] Scarlet Fever
- [ ] Heart Defect
- [ ] Heart Attack
- [ ] Chest Pain
- [ ] Difficulty Breathing
- [ ] Pace Maker
- [ ] Heart Surgery
- [ ] High Blood Pressure
- [ ] Congenital Heart Defect
- [ ] Jaundice/Liver Disease
- [ ] High Cholesterol
- [ ] Swelling of Ankles/feet
- [ ] Hepatitis A/B/C
- [ ] Stroke
- [ ] Sinus Problems
- [ ] Difficulty Breathing
- [ ] Asthma
- [ ] Fainting Spells
- [ ] Diabetes
- [ ] HIV+/AIDS
- [ ] Thyroid Problems
- [ ] Infective Endocarditis
- [ ] Abnormal bleeding
- [ ] Acid Reflux/GERD
- [ ] Acohol/Drug Abuse
- [ ] Allergies
- [ ] Arthritis
- [ ] Joint Replacement
- [ ] Eating Disorder
- [ ] Ulcers
- [ ] Kidney Problems
- [ ] Tuberculosis
- [ ] Persistant Cough
- [ ] Cancer
- [ ] Radiation Therapy
- [ ] Chemotherapy
- [ ] Sexually Transmitted Disease
- [ ] Epilepsy
- [ ] Anemia
- [ ] Glaucoma
- [ ] Nervousness
- [ ] Tonsillitis
- [ ] Tumors
- [ ] Mental Health
- [ ] Chemical Dependency
- [ ] Mitral Valve Prolapse
- [ ] Cold Sores
- [ ] Hypoglycemia
- [ ] Other medical conditions not listed _____
- [ ] **I have no medical conditions**

For Women

Are you currently pregnant? [ ] Yes [ ] No Are you currently Nursing? [ ] Yes [ ] No

Are you currently taking Birth control? [ ] Yes [ ] No
