

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

SS # _____
Date _____
Name _____ Birthdate _____ Home phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Cell phone _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
If student, name of school/college _____ City _____ State _____ Full Time Part Time
Patient or parent/guardian's employer _____ Work phone _____
Business address _____ City _____ State _____ Zip _____
Spouse or parent/guardian's name _____ Employer _____ Work phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
Email _____ Cell phone _____
Driver's license # _____ Birthdate _____ Financial institution _____
Employer _____ Work Phone _____ SS # _____
Is this person currently a patient in our office? Yes No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal check Credit card: VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of insured _____ Relationship to patient _____
Birthdate _____ SS# _____ Date employed _____
Name of employer _____ Union or Local # _____ Work phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance company _____ Group # _____ Policy ID # _____
Ins. co. address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____
Birthdate _____ SS# _____ Date employed _____
Name of employer _____ Union or Local # _____ Work phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance company _____ Group # _____ Policy ID # _____
Ins. co. address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office phone _____ Date of last exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	9. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	10. Are you allergic to or have you had any reactions to the following?		
If yes, explain _____			Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
			Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medications are you taking? _____			Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
			Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have or have you had any of the following?			Other (please list) _____		
	Yes	No	11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	12. Women Only:		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	c) Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
			Cancer	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
			Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
			Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Stomach Troubles / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
				Yes	No
			Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
			Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
			Hay Fever / Allergies	<input type="checkbox"/>	<input type="checkbox"/>
			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
			Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
			Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
			Other	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of previous dentist and location _____ Date of last exam _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received any oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing inaccurate information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. 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 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.

Signatures of patient (or parent/guardian if minor) _____ Date _____

Doctor's Comments _____

Signature _____ Date _____

Riverside Dental Center

Communication of Medical Information

PATIENT NAME: _____ BIRTHDAY _____

ADDRESS: _____ CITY: _____ STATE _____ ZIP: _____

HOME PHONE: _____ WORK/CELL PHONE: _____

I authorize Riverside Dental Center to communicate my medical information (please Check those that apply):

___ By leaving a message on my answering machine at home or on my cell phone.

___ By leaving a message on my answering machine at work.

___ By talking to a family member _____

(Insert Name or Names)

I give consent to have _____ bring the patient into the office for medical treatment.(please list name or names and relationship)

I understand that my medical information may include personal information regarding my care.

I understand that I may revoke this at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

DATE: _____
Signature of patient or legal representative

DATE: _____
If signed by other than the patient, state relationship

DATE: _____
Witness

Illinois mental health & Development Confidentiality Act Chapter 91.5, section 803-Minors ages 12-17 years old: patient, parent(legal guardian) and witness must sign and date.