



Welcome to River Square Family Dentistry

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check () yes or no if you have had problems with any of the following:

Y	N	Bad breath	Y	N	Food collection between teeth	Y	N	Periodontal treatment	Y	N	Sensitivity to sweets
Y	N	Bleeding gums	Y	N	Grinding or clenching teeth	Y	N	Sensitivity to cold	Y	N	Sensitivity when biting
Y	N	Clicking or popping jaw	Y	N	Loose teeth or broken fillings	Y	N	Sensitivity to hot	Y	N	Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____ Have

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

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check () yes or no whether you have had any of the following:

Y	N	AIDS/HIV Positive	Y	N	Cough, persistent	Y	N	Jaw pain	Y	N	Shingles
Y	N	Anaphylaxis	Y	N	Cough up blood	Y	N	Kidney disease or malfunction	Y	N	Shortness of breath
Y	N	Anemia	Y	N	Diabetes	Y	N	Liver disease	Y	N	Skin rash
Y	N	Arthritis, Rheumatism	Y	N	Epilepsy	Y	N	Material allergies (latex, wool, metal, chemicals)	Y	N	Spina Bifida
Y	N	Artificial heart valves	Y	N	Fainting	Y	N	Mitral valve prolapse	Y	N	Stroke
Y	N	Artificial joints	Y	N	Food allergies	Y	N	Nervous problems	Y	N	Surgical implant
Y	N	Asthma	Y	N	Glaucoma	Y	N	Pacemaker/Heart surgery	Y	N	Swelling of feet or ankles
Y	N	Atopic (allergy prone)	Y	N	Headaches	Y	N	Psychiatric care	Y	N	Thyroid disease or malfunction
Y	N	Back problems	Y	N	Heart murmur	Y	N	Rapid weight gain or loss	Y	N	Tobacco habit
Y	N	Blood disease	Y	N	Heart problems	Y	N	Radiation treatment	Y	N	Tonsillitis
Y	N	Cancer	Y	N	Hemophilia/Abnormal bleeding	Y	N	Respiratory disease	Y	N	Tuberculosis
Y	N	Chemical dependency	Y	N	Herpes	Y	N	Rheumatic/Scarlet fever	Y	N	Ulcer/Colitis
Y	N	Chemotherapy	Y	N	Hepatitis				Y	N	Venereal disease
Y	N	Circulatory problems	Y	N	High blood pressure						
Y	N	Cortisone treatments									

Is patient currently taking any medications? If yes, list all: _____

Does patient have drug allergies? If yes, list all: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Page 2 of 2