Riverside Dental
401 Main St. Savanna, IL 61074
Phone: (815) 273-2212
Fax: (515) 361-5393

Today's Date: _____

PATIENT INFORMATION

Name, Last:_____ First_____ Middle_____ DOB_____

Gender ☐ Male ☐ Female Social Security #_____-____-_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Home Phone # _____ Work # _____ Other # _____

Cell # _____ E-mail Address: _____

Address: _____ City: _____
Zip::_____

Employer: _____ Occupation: _____Work # _____

Emergency Contact: _____Phone # _____ Relationship_____

If Minor, Parent's Name: _____ Have you or any member of your family been a patient at this office before? ☐ Yes ☐ No Whom may we thank for recommending our office to you? _____ Otherwise, how did you learn about our practice? ☐ Insurance ☐ Internet ☐ Mailer ☐ Radio ☐ Community Event ☐ Other: _____

ACCOUNT RESPONSIBLE PARTY

Person Responsible for Account: _____

Currently a patient in our office(s)? ☐ Yes ☐ No Social Security # ____-____-____ DOB: _____

Driver's License: _____ State: _____ Home Phone # _____ Cell # _____

Email: _____ Address: _____

City: _____ State: _____ ZIP: _____

PRIMARY DENTAL INSURANCE

Insured's Name: _____DOB: _____ Relation to Patient: _____

Social Security #_____-____-_____ Member ID: _____ Effective Date: _____

Insurance Carrier: _____ Phone #_____ Employer:_____

Address: _____ City: _____ State: ____ ZIP:_____

Group or Policy #_____ Union/Group Name:_____

DENTAL HISTORY

What is the primary reason for your dental visit today?

_____

Are you aware of any dental problems? If so, please explain:

_____

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, sweets)
- ☐ Bleeding, swollen or irritated gums
- ☐ Tooth pain when chewing
- ☐ Teeth or filling breaking
- ☐ Loose, tipped or shifting teeth
- ☐ Dry Mouth
- ☐ Jaw Joint Pain
- ☐ Bad Breath or bad taste in mouth
- ☐ Grinding/Clenching teeth

If you could whiten your teeth for a cost you could afford would you do it? ☐ Yes ☐ No

If you could change anything about your smile it would be:

- ☐ Make them brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Alternative to a denture
- ☐ Replace old crowns that don't match
- ☐ Get a smile makeover
- ☐ Other_____

MEDICAL HISTORY

Please check any of the following that APPLIES TO THE PATIENT:

☐ Pre-Med-Amox	☐ Pre- Med- Clind	☐ Pre- Med- Other	☐ Anemia
☐ Allergy	☐ Allergy-Medications	☐ Alzheimer's/Dementia	☐ Artificial Joints
☐ Arthritis	☐ Asthma	☐ Blood Disease	☐ Blood Thinners
☐ Cancer	☐ Diabetes	☐ Dizziness/Fainting	☐ Epilepsy/Seizures
☐ Excessive Bleeding	☐ Gastric Disorders	☐ Glaucoma	☐ Head Injuries
☐ Heart Attack/ Stroke	☐ Heart Disease	☐ Heart Murmur/MVP	☐ Hepatitis
☐ HIV/Aids	☐ Kidney Disease	☐ Liver Disease	☐ Blood Pressure High/Low
☐ Nervous Disorders	☐ Osteoporosis Meds	☐ Other	☐ Pacemaker/Stents
☐ Psychiatric Care	☐ Radiation/Chemo	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ Tuberculosis	☐ Tumors/Growths
☐ Venereal Disease	☐ Stroke	☐ Anxiety/Depression	☐ Thyroid disease
☐ Seizures	☐ Latex Allergy	☐ Taking birth control	☐ Nursing
☐ Recent Hospitalization (illness or injury)		☐ Subject to frequent headaches or migraines	
☐ Presently being treated for any other illness		☐ Tobacco/Alcohol Use	
☐ Pregnant/Planning Pregnancy		☐ Diagnosed with Osteoporosis	

Do you use any recreational drugs? ☐ Yes ☐ No Which drugs? _____

What medical conditions are you currently being treated for? _____

Physicians name: _____ Phone # _____

Please list any **Medications** you are currently taking: _____

_____

_____

Please list any medications you are **Allergic** to or have bad reactions to: _____

To the best of my knowledge, I have answered every question completely and accurately. It is my responsibility to inform the dental office of any changes in my health and or medications.

Patient or Guardian signature:_____

Print Name: _____ **Date:** _____

HIPAA Acknowledgment

I understand that I may inspect or copy the protected health information described in this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be as effective as to the disclosure of records whose released I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I authorize this dental practice to release any financial or dental information to the following person(s) listed:

_____

Signature_____