Rivergate DENTAL

NEW PATIENT ADULT FORM

Today's Date: _____

E-Mail Address: _____

Name: _____
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: _____ ❒ Male ❒ Female

Birthdate: ___ / ___ / ___ Age: _____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

HM #: I_____I_____ Cell #: I_____I_____

WK #: I_____I_____ Ext: _____DL #: _____

Employer: _____

Employer's Address: _____

Occupation: _____

Whom may we THANK for referring you?_____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Person Responsible for Account

His / Her Name: _____ Relation: _____

HM #: I_____I_____ WK #: I_____I_____

Address: _____

_____
City State Zip

SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

WK #: I_____I_____ Ext: _____DL #: _____

Birthdate: ___ / ___ / ___ Age: _____ SS#: _____

MEDICAL and HIPAA
STATEMENT of UNDERSTANDING and ACCEPTANCE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that Rivergate Dental follows HIPAA privacy policies and procedures and I have been informed and offered a copy of the HIPAA policy. I understand that it is my responsibility to inform this office of any changes in my medical status.

_____
Signature Date

MEDICAL HISTORY

Do you have a personal physician? ❒ Yes ❒ No
Physician's Name: _____
Phone #: I_____I_____ Date of last visit: _____
Are you currently under the care of a physician? ❒ Yes ❒ No
Please explain: _____

Your current physical health is: ❒ Good ❒ Fair ❒ Poor
Do you smoke or use tobacco in any other form? ❒ Yes ❒ No
Have you had any metal rods, pins or implants? ❒ Yes ❒ No
Are you taking any prescription/over-the-counter or herbal supplemental drugs? ❒ Yes ❒ No
Please list each one: _____

_____
Have you ever taken Fosomax, or any other bisphosphonate? ❒ Yes ❒ No
Are you taking blood thinners/aspirin? ❒ Yes ❒ No
For Women: Are you using a prescribed method of birth control? ❒ Yes ❒ No
Are you pregnant? ❒ Yes ❒ No Week #: _____
Are you nursing? ❒ Yes ❒ No

Have you ever had any of the following diseases or medical problems:

Y N Abnormal Bleeding
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer /Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Osteoporosis/Paget's Disease
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Penicillin
Y N Erythromycin
Y N Latex
Y N Other
Y N Tetracycline
Y N Dental Anesthetics

Please list any other drugs/materials that you are allergic to: _____

_____
Do you require antibiotics before dental treatment? ❒ Yes ❒ No
Are you currently in pain? ❒ Yes ❒ No
Have you ever had a serious/difficult problem associated with any previous dental work? ❒ Yes ❒ No
Have you ever had gum treatment? ❒ Yes ❒ No
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❒ Yes ❒ No

Your current dental health is **❒ Good ❒ Fair ❒ Poor**
Do you like your smile? ❒ Yes ❒ No
Do your gums ever bleed? ❒ Yes ❒ No