riverside dental

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 any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health!

Patient Information

E-mail: Today's Date:

As required by law, our office adheres to written policies to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient Name: *Last* *First* *MI* *Preferred Name*

Gender: ☐ M ☐ F

Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: SS#:

Address: City: State: Zip:

Home Phone: include area code Business Phone: include area code Cell Phone: include area code

How would you prefer we contact you? ☐ Home ☐ Work ☐ Cell ☐ E-mail ☐ Other

If you are completing this form for another person, what is your relationship to that person?

Your name: Relationship:

In case of an emergency, who can we contact on your behalf?

Relationship: Contact Number: include area code

How did you hear about our office?

Employment and Insurance Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: Occupation:

Address: Phone Number:

Primary Insurance:

Name of Insured:

Is insured a patient?
☐ Yes ☐ No

ID #: Group #: Patient's relationship to Insured: Insured's Birth Date:

Insured's Employer Name: Address:

Insurance Plan Name and Address:

Secondary Insurance:

Name of Insured:

Is insured a patient?
☐ Yes ☐ No

ID #: Group #: Patient's relationship to Insured: Insured's Birth Date:

Insured's Employer Name: Address:

Insurance Plan Name and Address:

Medical Information

Are you now under the care of a physician? ☐ Yes ☐ No

Your Primary Care Physician's Name, Address and Phone Number:

Would you consider yourself to be in fairly good health? ☐ Yes ☐ No

Date of last physical exam:

Has there been any change in your general health within the past year? ☐ Yes ☐ No

If yes, what condition is being treated?

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ Yes ☐ No

If yes, what was the illness or problem?

Are you taking or have your recently taken any prescription or over the counter medicine(s)? ☐ Yes ☐ No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Do you wear contact lenses? ☐ Yes ☐ No

Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)? ☐ Yes ☐ No

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or ☐ Yes ☐ No

risedronate (Actonel) for osteoporosis or Paget's disease?

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐ No

Do you use controlled substances (drugs)? ☐ Yes ☐ No

Do you use tobacco (smoking or chewing)? ☐ Yes ☐ No

If so, are you interested in stopping? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No

If so, how much do you typically drink in a week? _____

WOMEN ONLY Are you:

Pregnant? ☐ Yes ☐ No

Number of weeks: _____

Taking birth control pills or hormonal replacement? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Joint Replacement—Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ Yes ☐ No

Date: _____ If yes, have you had any complications? _____

Allergies—Are you allergic to or have you had a reaction to:
To all *yes* responses, specify type of reaction.

Local anesthetics	☐ Yes ☐ No	Metals	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Latex (rubber)	☐ Yes ☐ No
Penicillin or other antibiotics	☐ Yes ☐ No	Iodine	☐ Yes ☐ No
Barbiturates, sedatives, or sleeping pills	☐ Yes ☐ No	Hay fever/seasonal	☐ Yes ☐ No
Sulfa drugs	☐ Yes ☐ No	Animals	☐ Yes ☐ No
Acrylics	☐ Yes ☐ No	Food	☐ Yes ☐ No
Codeine or other narcotics	☐ Yes ☐ No	Other	☐ Yes ☐ No
Nitrous Oxide (laughing gas)	☐ Yes ☐ No	_____	

Medical Conditions—Please mark your response to indicate if you have or have not had any of the following diseases or problems.

Heart murmur	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Mitral valve prolapsed	☐ Yes ☐ No	Low blood pressure	☐ Yes ☐ No
Artificial heart valves	☐ Yes ☐ No	Congenital heart defects	☐ Yes ☐ No
Rheumatic fever or Rheumatic heart disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Cardiovascular disease	☐ Yes ☐ No	Abnormal bleeding	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Anemia	☐ Yes ☐ No
Arteriosclerosis	☐ Yes ☐ No	Blood transfusion	☐ Yes ☐ No
Congestive heart failure	☐ Yes ☐ No	If yes, date: _____	
Coronary artery disease	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Damaged heart valves	☐ Yes ☐ No	AIDS or HIV infection	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Autoimmune disease	☐ Yes ☐ No	Hepatitis, jaundice or liver disease	☐ Yes ☐ No
Systemic lupus erythematosus	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Rheumatoid arthritis	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Fainting spells or seizures	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Neurological disorder	☐ Yes ☐ No
Sinus trouble	☐ Yes ☐ No	If yes, specify: _____	
Tuberculosis	☐ Yes ☐ No	Sleep disorder	☐ Yes ☐ No
Cancer/Chemotherapy/Radiation Treatment	☐ Yes ☐ No	Mental health disorders	☐ Yes ☐ No
Chest pain upon exertion	☐ Yes ☐ No	If yes, specify: _____	
Chronic Pain	☐ Yes ☐ No	Recurrent infections	☐ Yes ☐ No

Diabetic Type I or II	☐ Yes ☐ No	Type of infection:	
Eating Disorder	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No
Malnutrition	☐ Yes ☐ No	Night sweats	☐ Yes ☐ No
Gastrointestinal disease	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
GERD/Persistent heartburn	☐ Yes ☐ No	Persistent swollen glands in neck	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No	Severe headaches/migraines	☐ Yes ☐ No
Thyroid problems	☐ Yes ☐ No	Severe or rapid weight loss	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Sexually transmitted disease	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Excessive urination	☐ Yes ☐ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No
Name of physician or dentist making recommendation (please include contact information):

Do you have any disease, condition or problem not listed above that you think I should know about?
Please explain:

Dental Information

What is the reason for your dental visit today?

Are you currently experiencing dental pain or discomfort? ☐ Yes ☐ No
If so, please describe:

Do your gums bleed when you brush or floss?	☐ Yes ☐ No
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐ Yes ☐ No
Does food or floss catch between your teeth?	☐ Yes ☐ No
Is your mouth dry?	☐ Yes ☐ No
Have you had any periodontal (gum) treatments?	☐ Yes ☐ No
Have you ever had orthodontic (braces) treatment?	☐ Yes ☐ No
Have you had any problems associated with previous dental treatment?	☐ Yes ☐ No
Is your home water supply fluoridated?	☐ Yes ☐ No
Do you have earaches or neck pains?	☐ Yes ☐ No
Do you have any clicking, popping or discomfort in the jaw?	☐ Yes ☐ No
Do you brux or grind your teeth?	☐ Yes ☐ No
Do you have sores or ulcers in your mouth?	☐ Yes ☐ No
Do you wear dentures or partials?	☐ Yes ☐ No
Do you participate in active recreational activities?	☐ Yes ☐ No
Have you ever had a serious injury to your head or mouth?	☐ Yes ☐ No

Date of your last dental exam/cleaning: Date of your last dental x-rays:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction I will not hold my dentist, or any other member of his/her staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist/Witness: Date: