

RIVERBEND DENTAL

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|---|
| Patient Name: _____ Date: _____ Last, First MI (Preferred Name) Gender: _____ Family Status: Married Divorced Single |
| Social Security #: _____ Birth Date: ___/___/___ Drivers license # _____ |
| Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____ |
| Email Address: _____ |
| Address: _____ Street Apt # City State Zip Code |

Health Information

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Other Allergy _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

In case of emergency:

Emergency contact _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

(Signature of patient, parent or guardian) Date: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ ODL#: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell) _____

Address: _____ Apt# _____ City: _____ State _____ Zip: _____

Insurance Information

Primary

Name of Insured: _____ is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

If insured is a student:

School name _____ Full time/part time _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

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

Consent for Services

Payment is due at the time services are rendered. Patients who carry dental insurance understand that the estimated patient portion is due at the time services are rendered. This office will bill the patient's insurance and assist in making collections from the insurance company, however, this dental office cannot render services on the assumption that charges will be paid by an insurance company. I acknowledge I am financially responsible for all charges.

If it becomes necessary to effect collections of any amount owed, a \$125.00 collection fee will be assessed. I understand that if the account goes to collections, I am responsible for all legal costs and expenses, including reasonable attorney fees and I hereby authorize the doctor to release information necessary to secure payment. I grant permission to telephone me to discuss matters related to my account. Without a courtesy notice of 48 hours, I understand a \$50.00 fee will be applied to my account.

I have read and agree to the above conditions of payment.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____