Riverheart

FAMILY DENTISTRY

PATIENT INFORMATION

We are pleased to welcome you to our office. 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.

PERSONAL

Patient Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ DL# _____ Gender: ◯M ◯F Married: ◯Y ◯N

Work Phone_____ Cell Phone_____ Email_____

If patient is under 18 yrs, please also complete the following:

Guarantor *Name*_____
Last First MI (Preferred)

Birthdate_____ SS#_____ DL# _____ Gender: ◯M ◯F Married: ◯Y ◯N

Work Phone_____ Cell Phone_____ Email_____

Student status if dependent over 19 (for ins) ◯Nonstudent ◯Fulltime ◯Part time

How did you hear about us? (Please be specific so we can thank them!)_____

_____

ADDRESS AND HOME PHONE

Check circle if same for entire family: ◯

Address_____

Address 2_____

City_____ State_____ Zip_____

Home Phone_____

INSURANCE POLICY 1

Patient relationship to subscriber: ◯Self ◯Spouse ◯Child

Subscriber Name_____ Sub.ID # _____ Sub.DOB_____

Insurance Company _____ Phone_____

Employer_____ Group Name_____ Group #_____

INSURANCE POLICY 2

Patient relationship to subscriber: ◯Self ◯Spouse ◯Child

Subscriber Name_____ Sub.ID # _____ Sub.DOB_____

Insurance Company _____ Phone_____

Employer_____ Group Name_____ Group #_____

Comments:_____

Please complete reverse side.

FINANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance, and receive payment directly from them.
* If sent to collections, I agree to pay a **$30 collection fee**, all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* Treatment plans may change, and I will be responsible for the work actually done.

Signature_____ Date_____

MEDICAL HISTORY

Name of Medical Doctor:_____ City/State_____

Emergency Contact_____ Phone_____Relationship_____

List all the medications or drugs you are now taking:

[ ] None

_____

_____

_____

_____

Check medications or drugs you are allergic to:

- ◯ None
- ◯ Aspirin
- ◯ Codeine/ Other Narcotics
- ◯ Erythromycin
- ◯ Latex Rubber
- ◯ Local Anesthetics
- ◯ Metals
- ◯ Penicillin
- ◯ Sulfa Drugs
- ◯ Other: _____

Check any medical conditions you may have:

- ◯ None
- ◯ AIDS/HIV
- ◯ Alcohol/Drug Abuse
- ◯ Anemia/Leukemia
- ◯ Anorexia/Bulimia
- ◯ Arthritis
- ◯ Asthma/Hay Fever
- ◯ Blood Clotting Problems
- ◯ Blood Transfusion
- ◯ Bronchitis
- ◯ Cancer/Tumor or Growth
- ◯ Cardiac Pacemaker
- ◯ Chest Pain Upon Exertion
- ◯ Damage Heart Valve
- ◯ Diabetes
- ◯ Emphysema
- ◯ Epilepsy
- ◯ Fainting Spells/Seizures
- ◯ Fever Blisters/Herpes
- ◯ Frequent Headaches
- ◯ Frequently Dry Mouth/Sjogren
- ◯ Gall Bladder Trouble
- ◯ Heart Attack/Stroke
- ◯ Heart Disease/Angina
- ◯ Heart Murmur
- ◯ Hepatitis/Jaundice
- ◯ High Blood Pressure
- ◯ Hives/Skin Rash
- ◯ Joint Replacement, Date of: _____
- ◯ Kidney/Bladder Trouble
- ◯ Liver Disease
- ◯ Low Blood Pressure
- ◯ Mental Health Problems
- ◯ Mitral Valve Prolapse
- ◯ Persistent Diarrhea
- ◯ Rheumatic Fever
- ◯ Rheumatic Heart Disease
- ◯ Sexually Transmitted Disease
- ◯ Sinus Trouble
- ◯ Stomach Ulcers
- ◯ Thyroid Problems
- ◯ Tuberculosis
- ◯ Other: _____

Tobacco use? If so, what kind and how much?_____

Unusual reaction to dental injections?_____

Reason for today's visit:_____ Are you in pain? Yes / No

New patients:

Name of former dentist_____ City/State_____

Date of last cleaning and exam_____

WOMEN ONLY- Are you pregnant or do you have reason to believe you may be? ◯Yes / ◯No

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Name (printed) Date

_____

Patient/Guardian Signature

HIPAA - Patient Consent of Information

Riverheart Dentistry, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of Riverheart Family Dentistry from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Riverheart Family Dentistry physicians and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Riverheart physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply)

_____ on an answering machine or voicemail at home or cell phone
_____ on an answering machine or voicemail at work
_____ with _____ relationship _____
with _____ relationship _____
with _____ relationship _____

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly.

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Witness Date

HIPAA – Notice of Privacy Practice Acknowledgement

____ I have been provided a copy of Riverheart Dentistry Privacy Practice.
____ I have declined a copy of Riverheart Dentistry Notice of Privacy Practice.

_____ _____
Patients Signature Date

Appointment Cancellation Policy

Here at Riverheart Family Dentistry we strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an appointment cancellation policy. In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment.

Our policy is as follows:

We require that you give our office 24 hours' notice in the event that you need to reschedule your appointment. This will allow for other patients to be scheduled into that time slow. If you miss an appointment without contacting our office within the 24 hours, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. Thank you.

I have read and understand the appointment cancellation policy of Riverheart Family Dentistry. I agree to be bound by the terms. I understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name) have received a copy of Riverheart Family Dentistry's Appointment Cancellation Policy.

_____ _____

Patient or guardians signature **Date**

Riverheart Family Dentistry

Hygiene Patient Survey

Are you a smoker? Yes No

Do you chew or use smokeless tobacco? Yes No

Are you a female over the age of 16? Yes No

Do your gums bleed at all when brushing or flossing? Yes No

Do you get cold sores? Yes No

Do you have a dry mouth? Yes No

Do you have sensitive teeth? Yes No

Have you had a cavity in the last year? Yes No

Are you happy with your smile? Yes No

Do you grind your teeth? Do people comment that you grind? Yes No

Do you participate in leisure or athletic sports? Yes No

Do you want to keep your teeth all your life? Yes No

Consent to Prophylaxis (Cleaning)

Patient Name:_____

It has been recommended by your general dentist at Riverheart Family dentistry that you receive a prophylaxis (cleaning) by a Registered Dental Hygienist or Dentist. Dental cleanings are essential for maintaining health in your mouth. Overtime bacteria, food debris, and calcified (hardened) material accumulate on your teeth that your tooth brush cannot remove. Some people get this accumulation much quicker and in greater amounts than others. It may be recommended that you receive a professional cleaning every 3, 6, or 12 months depending on your level of need.

At Appointment Today:

1. Removal of plaque and calculus with metal instruments and ultra-sonic scalers
2. Coronal polishing
3. Flossing of teeth
4. Taking of radiographs (X-rays)
5. Application of fluoride
6. Provide oral hygiene instructions

Benefits:

1. Remove plaque and calculus that can aid in development of cavities or gum disease
2. Instruct patient in proper home care
3. Prevent pre-mature loss of teeth from gum disease
4. Make teeth more resistant to cavities with the application of fluoride

Risks:

1. Teeth may become sensitive to air, hot or cold stimuli
2. TMU (Jaw Joint) may become tender due to prolonged mouth opening
3. Tenderness may be present in the gums for a short time after a cleaning

I acknowledge that all procedures and costs are been explained to me and I give my consent for treatment.

Patients Signature: _____ Date: _____