

RIVER HILLS DENTISTRY

GENERAL • COSMETIC • IMPLANTS • PERIODONTICS

4337 Lynx Paw Trail ♦ Valrico ♦ Florida ♦ 33569 ♦ (813) 654-4223

DATE: _____

Please fill out this form completely in ink (confidential.) If you have any questions please ask us – we will be happy to help.

Patient Information:

SSN: _____

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Circle What Applies: Child / Single / Married / Divorced / Separated / Widowed

If Student, Name of School _____ Circle One: Full Time / Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Spouse/Parent/Guardian's Name _____ Phone _____

Whom May We Thank you Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party:

Name of Person Responsible for Account _____ Relationship to Patient _____

Driver's License Number _____ Date of Birth _____

Email _____ Phone _____ Current Patient: Y / N (circle one)

Employer _____ Work Phone _____ SSN _____

Insurance Information:

Name of Insured _____ Relationship to Patient _____

Subscriber ID#/SSN _____ Date of Birth _____

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Patient Medical History

Physician _____ Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain	<hr/>	
3. Are you taking any medication(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please List	<hr/>	
If you have a list of medications, please provide the front office staff with a copy.		
4. Have you ever Taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use tobacco or any related tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have a persistent cough or throat clearing not associated with a known illness (last more than 3 weeks?)	<input type="checkbox"/>	<input type="checkbox"/>
9. Women Only:		
a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
b) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
c) Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you allergic to or have you had any reactions to the following?		

Local Anesthetics (e.g. Novocaine)	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Penicillin or any other Antibiotics	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Sulfa Drugs	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Barbiturates	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Sedatives	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Iodine	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Latex Rubber	<input type="checkbox"/> Yes / <input type="checkbox"/> No

Other (please list) _____

11. Do you have or have you ever had any of the following?

High Blood Pressure	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Joint Replacement/Implants	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes / <input type="checkbox"/> No	COPD	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Swollen Limbs	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Fainting/Seizures	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Tumor or Growths	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Epilepsy/Convulsions	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Leukemia	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Hay Fever/Allergies	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Mental Illness	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Stomach Troubles/Ulcers	<input type="checkbox"/> Yes / <input type="checkbox"/> No
AIDS/HIV Infection	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Chest Pains	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Herpes	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Sexually Transmitted Disease	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Thyroid Problem	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Weight Gain or Loss	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Cardiac Pacemaker	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Heart Trouble	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Frequently Tired	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Bell's Palsy	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Bleeding Problems	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Respiratory Problems	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes / <input type="checkbox"/> No

Other (please list) _____

Patient Dental History:

Name of Previous Dentist and Location _____

Date of Last Dental Exam _____ Date of Last Dental Cleaning _____

Do you wear Dentures or partials? Yes / No If yes, how old are they _____

Do any of the following Dental concerns apply to you?

Bad Breath	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Missing Teeth	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Bleeding Gums	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Sensitivity to pressure	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Blisters on Lips or in Mouth	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Sensitivity to hot or cold	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Burning Sensation on Tongue	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Stained/Dark teeth	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Clicking/Popping/Swollen/Tender Jaw	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Spaces/Gaps between teeth	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Clenching/Grinding of your teeth	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Tooth pain or aches	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Dry Mouth	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Head/Neck/Jaw injuries	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Food collection/packing between teeth	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Difficult extractions in the past	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Lip or Cheek biting	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Prolonged bleeding from extractions	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Loose or Broken Teeth	<input type="checkbox"/> Yes / <input type="checkbox"/> No	Do you like your smile	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Loose or Broken fillings/crowns	<input type="checkbox"/> Yes / <input type="checkbox"/> No		

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient (or parent/guardian if minor)

X

Doctor's Signature

Date: _____

Date: _____