SOUTHERN RIVERS
DENTAL

Patient # _____
SSN _____

Patient Information

Name _____ Date of Birth _____/_____/_____

Address _____

Email _____ Phone _____

Spouse/Parent _____ Phone _____

Spouse/Parent Employer _____

Emergency Contact _____ Phone _____

Responsible Party

Person responsible for account _____

Relationship to patient _____ Phone _____

Address _____ Employer _____

Currently a patient in our office? Y ▢ N ▢ Email _____

Insurance Information

Name of insured _____ Relation to patient _____

SSN _____ Date of Birth _____/_____/_____

Employer _____ Insurance Company _____

Group Number _____

Additional Insurance

Name of insured _____ Relation to patient _____

SSN _____ Date of Birth _____/_____/_____

Employer _____ Insurance Company _____

Group Number _____

Dental History

Reason for today's visit _____

Date of last dental care _____ How often do you floss _____

How often do you brush _____

Please check if you have had problems with any of the following:

▢ Bad breath	▢ Grinding teeth	▢ Sensitivity to hot
▢ Bleeding gums	▢ Loose teeth or broken fillings	▢ Sensitivity to sweets
▢ Clicking or popping jaw	▢ Periodontal treatment	▢ Sensitivity to biting
▢ Food collection between teeth	▢ Sensitivity to cold	▢ Sores or growths

Medical History

Physician's name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Y ▢ N ▢

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Y ▢ N ▢

Have you had any serious illnesses or operations? Y▢ N ▢ If yes, please describe _____
_____

Have you ever had a blood transfusion? Y ▢ N ▢ If yes, please give approximate dates _____
(Women) Are you pregnant? Y ▢ N ▢ Nursing? Y▢ N ▢ Taking birth control? Y▢ N ▢

Place a mark on "yes" or "no" to indicate if you have had any of the following:

YES	NO		YES	NO		YES	NO	
▢	▢	Anemia	▢	▢	Congenital Heart Lesions	▢	▢	Hepatitis
▢	▢	Arthritis	▢	▢	Cortisone Treatments	▢	▢	Hernia Repair
▢	▢	Artificial Heart Valves	▢	▢	Cough, Persistent	▢	▢	High Blood Pressure
▢	▢	Artificial Joints, Pins	▢	▢	Cough up blood	▢	▢	HIV/AIDS
▢	▢	Asthma	▢	▢	Diabetes	▢	▢	Jaw pain
▢	▢	Scarlet Fever	▢	▢	Shortness of breath	▢	▢	Skin Rash
▢	▢	Swelling of feet/ankles	▢	▢	Back Problems	▢	▢	Epilepsy
▢	▢	Kidney Disease	▢	▢	Thyroid Problems	▢	▢	Abnormal Bleeding
▢	▢	Fainting	▢	▢	Liver Disease	▢	▢	Tobacco Habit
▢	▢	Blood Disease	▢	▢	Glaucoma	▢	▢	Mitral Valve Prolapse
▢	▢	Tonsilitis	▢	▢	Cancer	▢	▢	Headaches
▢	▢	Pacemaker	▢	▢	Tuberculosis	▢	▢	Chemical Dependency
▢	▢	Heart Murmur	▢	▢	Radiation Treatment	▢	▢	Ulcer
▢	▢	Chemotherapy	▢	▢	Heart Problems	▢	▢	Respiratory Disease
▢	▢	Venereal Disease	▢	▢	Circulatory Problems	▢	▢	Hemophilia
▢	Rheumatic Fever							

List medications you are currently taking and the correlating diagnosis: Allergies:

_____ _____
_____ _____
_____ _____

Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if i, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____

name of insurance company(ies)

and assign directly to Dr. _____ all insurance benefits., if any, otherwise payable to me for services rendered. I understand that i am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.