SOUTHERN RIVERS
DENTAL

Southern Rivers New Patient Registration Form

First Name _____ **Middle Initial** ____ **Last Name** _____ **Date** _____
Preferred Name _____
Patient is ___ **Responsible Party** ___ **Policy Holder** ___ **Male** ___ **Female** ___ **Married** ___ **Single**
Responsible Party/Policy Holder for Patient ___ Primary Policy Holder ___ Secondary Policy Holder

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Patient Information
Address _____
City, State, Zip_____
Home Phone _____ Work Phone _____ Cell Phone _____
Birth Date _____ Social Security # _____ Drivers Licence # _____ State _____
Employer _____
Email _____ I would like to receice email correspondence _____
Preferred Pharmacy _____ Referred By _____
Previous Dentist _____
Emergency Contact _____ Phone # _____

Primary Insurance Information
Name of Insured _____ Relationaship to Insured ___ Self ___ Spouse ___ Child ___ Other
Group ID # _____ Member ID# _____
Insured SSN _____ Insured Birth Date _____
Employer _____ Insurance Co. _____

Secondary Insurance Information
Name of Insured _____ Relationaship to Insured ___ Self ___ Spouse ___ Child ___ Other
Insured SSN _____ Insured Birth Date _____
Employer _____ Insurance Co. _____

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 _____, 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 companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date shown below.

Southern Rivers Dental files all PPO insurance as a courtesy to the patients. Patients are responsible for anything not covered by the insurance. We do not accept any contracts with any insurance companies. In most cases we are out of network. Each plan is different, and our goal is to give you the closest estimate possible. The patient is responsible for the difference between our fee and the amount the insurance company pays.

I understand that payment in full is expected at the time of service unless prior arrangements have been approved.

Guarantor/Patient Signature _____ Date _____
Guarantor/Patient Printed Name _____ Relationship to Patient _____

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HIPAA

This is an acknowledgement of receipt of the Notice of Privacy Practices and the Health Insurance Portability and Accountability Act (HIPAA).

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature of recipient _____ Relationship to patient _____

Whom may we speak to on your behalf:

Name: _____ Relationship _____ Phone _____
Name: _____ Relationship _____ Phone _____
Name: _____ Relationship _____ Phone _____

I give permission for the office to contact me by text @ _____ or by email @ _____
It is acceptable for the staff to leave voicemails pertaining to appointments and care. Yes ___ No ___

Signature _____ Date _____

below is for office use only

If consent was not received, please note as to why below.

__ Individual refused to sign
__ Communication barrier prohibited acknowledgement
__ An emergency situation prevented acknowledgement
__ Other _____

Date _____ Employee _____

SOUTHERN RIVERS
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MEDICAL HISTORY

Patient Full Name _____ **Preferred Name** _____ **Age** _____
Name of Physician and their specialty _____
Most recent physical examination _____ **Purpose** _____
What is your estimate of your general health? ___ **Excellent** ___ **Good** ___ **Fair** ___ **Poor**

Do you have OR have you ever had:	**Yes**	**No**
1. hospitalization for illness or injury	☐	☐
2. an allergic reaction to	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ sulfa		
☐ local anesthetic		
☐ flouride		
☐ metals (nickel, gold, silver, copper, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect (PFO)	☐	☐
6. ☐ pacemaker		
☐ implantable defibulator		
7. orthopedic implant (joint replacement)	☐	☐
8. rheumatic or scarlet fever	☐	☐
9. ☐ high blood pressure		
☐ low blood pressure		
10. a stroke (taking blood thinners)	☐	☐
11. ☐ anemia		
☐ other blood disorder		
12. prolonged bleeding due to a slight cut (NR > 3.5)	☐	☐
13. ☐ emphysema		
☐ shortness of breath		
☐ sarcoidosis		
14. ☐ tuberculosis		
☐ measles		
☐ chicken pox		
15. asthma	☐	☐
16. breathing or sleep problems (sleep apnea, snoring, sinus)	☐	☐
17. kidney disease	☐	☐
18. liver disease	☐	☐
19. jaundice	☐	☐
20. ☐ thyroid disease		
☐ parathyroid disease		
☐ calcium deficiency		
21. hormone deficiency	☐	☐
22. ☐ high cholesterol		
☐ taking statin drugs		
23. diabetes (HbA1c = _____)	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. digestive disorders (celiac disease, gastric reflux)	☐	☐
26. osteoporosis/osteopenia (taking bisphosphonates)	☐	☐

	Yes	**No**
27. arthritis	☐	☐
28. autoimmune disease	☐	☐
29. glaucoma	☐	☐
30. contact lenses	☐	☐
31. ☐ head injury		
☐ neck injury		
32. ☐ epilepsy		
☐ convulsions (seizures)		
33. neurologic disorders (ADD/ADHD, prion disease)	☐	☐
34. ☐ viral infections		
☐ cold sores		
35. any lumps or swelling in the mouth	☐	☐
36. ☐ hives		
☐ skin rash		
☐ hay fever		
37. STI/STD/HPV	☐	☐
38. hepatitis (type _____)	☐	☐
39. HIV/AIDS	☐	☐
40. tumor, abnormal growth	☐	☐
41. radiation therapy	☐	☐
42. chemotherapy, immunosuppressive medication	☐	☐
43. emotional difficulties	☐	☐
44. psychiatric treatment	☐	☐
45. anitdepressant medication	☐	☐
46. ☐ alcohol		
☐ recreational drug use		
ARE YOU:		
47. presently being treated for any other illness	☐	☐
(explain) _____		
48. aware of a change in your health in the past 24 hours (fever, chills, new cough, diarrhea)	☐	☐
49. taking medication for weight management	☐	☐
50. taking dietary supplements	☐	☐
51. often exhausted or fatigued	☐	☐
52. experiencing frequent headaches	☐	☐
53. ☐ a smoker		
☐ smoked previously		
☐ use smokeless tobacco		
54. considered a touchy or sensitive person	☐	☐
55. often unhappy or depressed	☐	☐
56. FEMALE - pregnant	☐	☐
57. MALE - prostate disorders	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment (i.e. Botox, Collagen injections) _____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please advise us in the future of any change in your medical history or any medications you may be taking

Patient's Signature _____ Date _____ Doctor's Signature _____ Date _____

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DENTAL HISTORY

Patient Full Name _____ **Preferred Name** _____ **Age** _____
Referred by _____ **How would you rate the condition of your mouth?** __ **Excellent** __ **Good** __ **Fair** __ **Poor**
Previous Dentist _____ **How long had you been a patient?** ___ **Months** ___ **Years**
Date of most recent dental exam ___/___/___ **Date of most recent x-rays** ___/___/___
Date of most recent treatment (other than cleaning) ___/___/___
I routinely see my dentist every ☐ **3 months** ☐ **4 months** ☐ **6 months** ☐ **12 months** ☐ **Not routinely**
What is your immediate concern? _____

Please answer Yes OR No to the following:	**Yes**	**No**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) ____	☐	☐
2. Have you had an unfavorable dental experience	☐	☐
3. Have you ever had complications from past dental treatments?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodonic treatment or had your bite adjusted?	☐	☐
6. Have you ever had teeth removed?	☐	☐
GUM & BONE		
7. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning sensation in your mouth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting or craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE & JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. Have your teeth changed in the last 5 years, becoming shorter, thinner, or worn?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or rest your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench your teeth in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleed (i.e. restlessness), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance if your teeth that you would change?	☐	☐
34. Have you ever whitened (bleached) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____