Riverstone DENTAL

Decatur
234 N. 1st St.
Decatur, IN 46733
(260) 724-7032

Bluffton
1429 N. Baker Pl.
Bluffton, IN 46714
(260) 824-4614

www.RiverstoneDental.net

PATIENT INFORMATION

PERSONAL INFORMATION

Today's Date____/____/____ File #____

Patient's Name ____ (____)
LAST FIRST MI PREFERRED OR NICK NAME

Patient's Address: Street, Apt #____ City____ State ____ Zip____

Home Phone #____ Work Phone #____ Ext____ Cell Phone #____

E-mail ____ Marital Status: ❒Single ❒Married ❒Separated ❒Divorced ❒Widowed ❒Minor

Spouse's Name____ Do you have children? ❒Yes ❒No How many?____

Social Security # ____ ❒Male ❒Female Age____ Date of Birth____
MONTH / DAY / YEAR

Patient Employer/School ____ How Long?____ Occupation____

Employer/School: Street____ City____ State____ Zip____ Phone #____

Referred by: ❒Radio ❒Newspaper ❒Phonebook ❒Website ❒Facebook ❒Friends or Family ____

INSURANCE

Primary Dental Insurance Company Name____ Phone #____

Insurance Company Address ____ City____ State____ Zip____

Insured's Name____ Policy #____ Group #____

Relation to Patient____ Insured's Employer____ Date of Birth____
MONTH / DAY / YEAR

Secondary Dental Insurance Company Name____ Phone #____

Insurance Company Address ____ City____ State____ Zip____

Insured's Name____ Policy #____ Group #____

Relation to Patient____ Insured's Employer____ Date of Birth____
MONTH / DAY / YEAR

EMERGENCY

Emergency Contact Name____ Relation ____

Home Phone #____ Work Phone #____ Cell Phone #____

Who is your Medical Doctor?____ Doctor's Phone #____

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DENTAL & MEDICAL INFORMATION

DENTAL HISTORY

Reason for today's visit? ❒Exam ❒Emergency ❒Consultation Are you in pain? ❒Yes ❒No How long?_____

Please indicate ☑any of the following problems:

❒Discomfort, clicking or popping in jaw
❒Red, swollen or bleeding gums
❒Sensitive tooth, teeth or gums
❒Blisters/sores in or around mouth
❒Lost/broken filling(s)
❒Teeth grinding
❒Ringing in ears
❒Broken/chipped tooth
❒Stained teeth
❒Locking jar
❒Bed breath

Other: _____

Do you require pre-medication? ❒Yes ❒No ❒Don't know

Previous Dentist _____Last Dental exam___/___/____Last Dental X-rays___/___/____

Times a day you brush?_____Times a week you floss?_____Type of tooth brush bristles you use ❒Soft ❒Medium ❒Hard

How would you rate your smile? (worst) ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 (best)

MEDICAL HISTORY

What medications are you taking? ❒Nerve pills ❒Pain killers (including aspirin) ❒Muscle relaxers ❒Stimulants ❒Insulin ❒Blood thinners ❒Tranquilizers ❒Osteoporosis Medication ❒Other(s)_____

_____

Have you ever taken: Bisphosphonates (e.g. Aredia/Fosamax) ❒Yes ❒No Phen-fen/Redux ❒Yes ❒No

Do you have or have you had any of the following diseases, medical conditions or procedures?

❒Yes ❒No Heart attack/stroke	❒Yes ❒No Thyroid problems	❒Yes ❒No Cancer/tumors	❒Yes ❒No Cosmetic surgery
❒Yes ❒No Heart surgery/pacemaker	❒Yes ❒No Kidney problems	❒Yes ❒No Shingles	❒Yes ❒No -X-ray/Cobalt treatment
❒Yes ❒No Heart murmur	❒Yes ❒No Liver problems	❒Yes ❒No Hepatitis	❒Yes ❒No Chemotherapy
❒Yes ❒No Rheumatic fever	❒Yes ❒No Respiratory problems	❒Yes ❒No HIV+/AIDS/ARC	❒Yes ❒No Asthma
❒Yes ❒No Mitral valve prolapse	❒Yes ❒No Sinus problems	❒Yes ❒No Arthritis/rheumatism	❒Yes ❒No Difficulty breathing
❒Yes ❒No Artificial valves	❒Yes ❒No Stomach problems/ulcers	❒Yes ❒No Artificial bones/joints	❒Yes ❒No Diabetes/hypoglycemia
❒Yes ❒No Heart disease	❒Yes ❒No Psychiatric problems	❒Yes ❒No Emphysema	❒Yes ❒No Leukemia
❒Yes ❒No Congenital heart defect	❒Yes ❒No Venereal disease	❒Yes ❒No Fainting/seizures/epilepsy	❒Yes ❒No Anemia
❒Yes ❒No Chest pains	❒Yes ❒No Alcohol/drug abuse	❒Yes ❒No Severe/frequent headaches	❒Yes ❒No High/low blood pressure
❒Yes ❒No Scarlet fever	❒Yes ❒No Tuberculosis TB	❒Yes ❒No Frequent neck pain	❒Yes ❒No Bleeding problems
❒Yes ❒No Nervousness	❒Yes ❒No Jaw problems TMJ/TMD	❒Yes ❒No Back problems	❒Yes ❒No Glaucoma

Please list any other surgeries or medial conditions you have had_____

_____

Are you allergic to any of the following? ❒Latex ❒Penicillin/Amoxicillin ❒Tetracycline ❒Aspirin ❒Dental Anesthetics

❒Foods_____ ❒Others_____

Do you use tobacco ❒No ❒Yes/how used?_____How much?_____How long?_____

Please rate your general health from 1-10 (10 is best)_____Do you wear contact lenses? ❒Yes ❒No

For women:

Do you take birth control pills? ❒Yes ❒No Are you pregnant? ❒Yes ❒No If yes, how long?_____Are you nursing?❒Yes ❒No

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ACCOUNT INFORMATION / AUTHORIZATION

PAYMENT INFORMATION

Person ultimately responsible for account

Name_____ Relation to Patient_____

Billing Address: Street, Apt #_____ City_____ State _____ Zip _____

Home Phone #_____ Work Phone #_____ Ext_____ Cell Phone #_____

Payment Method ❒Cash ❒Credit Credit Card #_____ Expiration____/____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Signature X_____ Date_____

AUTHORIZATION

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I acknowledge that I have received a copy of the Summary of Privacy Notice.

Signature X_____ Date_____

❒Adult Patient ❒Parent or Guardian ❒Spouse

OFFICE USE ONLY

Initials_____ Date_____ Comments_____

Initials_____ Date_____ Comments_____

Initials_____ Date_____ Comments_____

Initials_____ Date_____ Comments_____

Initials_____ Date_____ Comments_____

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Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____
Patient Signature Patient Name (please print)

I am also signing for my minor children: _____
(please print names)

Date: _____

Patient Consent

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____ _____
Patient Signature Patient Name (please print)

I am also signing for my minor children: _____
I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, caregiver)

_____
(please print names)

_____

_____

Date: _____

For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement:

_____

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

_____ _____
Office Personnel (signature) Office Personnel (print name)

Date: _____