

DRS. RICE AND RICE - FAMILY DENTISTRY

PATIENT INFORMATION

LAST NAME: _____ FIRST: _____ MI: _____ BIRTH DATE: _____
ADDRESS: _____ HOME PHONE NO.: _____ SEX: _____
C/S/ZIP: _____ SOCIAL SECURITY NO.: _____
EMPLOYER: _____ WORK PHONE NO.: _____
ADDRESS: _____ C/S/ZIP: _____

GUARANTOR'S INFORMATION (If different from patient)

LAST NAME: _____ FIRST: _____ MI: _____ BIRTH DATE: _____
ADDRESS: _____ HOME PHONE NO.: _____ SEX: _____
C/S/ZIP: _____ SOCIAL SECURITY NO.: _____
EMPLOYER: _____ WORK PHONE NO.: _____
ADDRESS: _____ C/S/ZIP: _____

SPOUSE INFORMATION

LAST NAME: _____ FIRST: _____ MI: _____ BIRTH DATE: _____
ADDRESS: _____ HOME PHONE NO.: _____ SEX: _____
C/S/ZIP: _____ SOCIAL SECURITY NO.: _____
EMPLOYER: _____ WORK PHONE NO.: _____
PREVIOUS EMPLOYER: _____

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER: _____
NAME OF POLICY HOLDER/SUBSCRIBER: _____
SUBSCRIBER NO.: _____ GROUP NO.: _____ CONTRACT NO.: _____
SECONDARY CARRIER: _____
ADDRESS: _____
SUBSCRIBER NO.: _____ GROUP NO.: _____ CONTRACT NO.: _____

OTHER INFORMATION

RELATIVE NOT LIVING WITH YOU TO CONTACT IN CASE OF AN EMERGENCY: _____
ADDRESS: _____
C/S/ZIP: _____ HOME PHONE NO.: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and all members of my family promptly upon presentment thereof. I hereby authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendency of claims thereon. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance.

I hereby authorize the release of any pertinent information to my insurance company and any other doctors involved in my case. If my account becomes assigned to a collection agency, I agree to pay 25% collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed a 1.5 percent late charge per month on the unpaid monthly balance.

SIGNED (Patient): _____ DATE: _____

SIGNED (Guarantor): _____ DATE: _____

Welcome to Blue Ridge Dental Arts

Name: _____

Date: _____

DENTAL HISTORY	YES	NO
When was the last time you had your teeth cleaned? _____		
Have you ever been told you have gum disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had your gums measured? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any gum surgery? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any orthodontic treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever visited a dental specialist such as:		
A periodontist? _____	<input type="checkbox"/>	<input type="checkbox"/>
An endodontist? (ex: root canal) _____	<input type="checkbox"/>	<input type="checkbox"/>
An oral surgeon? _____	<input type="checkbox"/>	<input type="checkbox"/>
GUM DISEASE WARNING SIGNS (Do any of these apply to you?)		
Gums that bleed when you brush your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Gums that are red, swollen, or tender? _____	<input type="checkbox"/>	<input type="checkbox"/>
Pus between teeth and gums when gums are pressed? _____	<input type="checkbox"/>	<input type="checkbox"/>
Gums that have pulled away (receded) from teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Permanent teeth that are loose or separating? _____	<input type="checkbox"/>	<input type="checkbox"/>
Change in the way that your teeth fit when biting? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any change in the fit or your partial dentures? _____	<input type="checkbox"/>	<input type="checkbox"/>
Persistent bad breath? _____	<input type="checkbox"/>	<input type="checkbox"/>
ESTHETIC CONCERNS		
Are you unhappy with the appearance of your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in whitening your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in straightening your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>

Welcome to Blue Ridge Dental Arts

Name: _____

Date: _____

MEDICAL HISTORY

Are you currently taking any medications (include prescriptions, over-the-counter, and herbal/naturopathic remedies.) Yes No

List: _____

Are you taking Asprin once a day as a blood thinner? Yes No

Are you allergic to any medications? Yes No

List: _____

Do you have a latex allergy or any other topical/food allergies? Yes No

Describe: _____

Do you have a heart murmur/mitral valve prolapse, prosthetic heart valve, atrial/ventricular shunt or have you ever had rheumatic fever? Yes No

Describe: _____

Have you ever had joint surgery or a joint replacement? Yes No

Describe: _____

Have you had any medical procedures done within the last two (2) years? Yes No

Describe: _____

Are you under the care of your physician for any reason? Yes No

Describe: _____

Are you being treated for osteoporosis or cancer? yes No

Describe: _____

Are you currently pregnant? Yes No If Yes, when is your due date? _____

Welcome to Blue Ridge Dental Arts

Name: _____

Date: _____

MEDICAL HISTORY (Continued) – Please check any items not previously mentioned						
	YES	NO			YES	NO
A.I.D.S.	<input type="checkbox"/>	<input type="checkbox"/>		High/low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>		Hodgkins disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>		Hyper /Hypo Glycemia	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>		Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>		Inflammatory bowel	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints (hip, knee)	<input type="checkbox"/>	<input type="checkbox"/>		Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>		Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Lung disease	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>		Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>		Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart lesions	<input type="checkbox"/>	<input type="checkbox"/>		Medical implant	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids	<input type="checkbox"/>	<input type="checkbox"/>		Mental/nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>		Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>		Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>		Scarlet/rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Glandular disorders	<input type="checkbox"/>	<input type="checkbox"/>		Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Head/Neck injuries	<input type="checkbox"/>	<input type="checkbox"/>		Stomach/intestinal /ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease / Attack	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm Disorder	<input type="checkbox"/>	<input type="checkbox"/>		Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>		Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis __A __B __C	<input type="checkbox"/>	<input type="checkbox"/>		Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>		Other _____	<input type="checkbox"/>	<input type="checkbox"/>