Rio Vista
FAMILY DENTISTRY

New Patient Paperwork

NAME:

Last: _____ First: _____ MI: _____ Nickname: _____

ADDRESS:

Street: _____

City: _____ State: _____ Zip: _____

DOB: _____ Male Female SSN#: _____-_____-_____

Home: (____)_____ Work: (____)_____ Mobile: (____)_____

Email: _____ If applicable, Spouse's Name:_____

Emergency Contact Name: _____ Phone: (_____) _____

How would you like to receive reminders? (Please circle): Phone call, Email, Text

Employer: _____ May we contact you at work? YES, NO

How did you hear about us? _____

DENTAL INSURANCE

Primary Dental Carrier

Subscriber Name: _____ SSN#: _____-____-_____ DOB: _____

Insurance Company: _____ Insurance Phone #: _____

Employer: _____ Group #: _____ Relation to Patient: _____

Secondary Dental Carrier

Subscriber Name: _____ SSN#: _____-____-_____ DOB: _____

Insurance Company: _____ Insurance Phone #: _____

Employer: _____ Group #: _____ Relation to Patient: _____

Patient Signature: _____ Date: _____

If patient is under 18: _____ Relation to patient: _____

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HEALTH HISTORY

Are you currently under care of a physician for a health issue? _____

Name of Physician: _____ Phone: _____

Date of last physical: _____ How do you assess your current health? Good/Fair/Poor

Check the box to indicate if you currently have or had any of the following conditions:

Acid Reflux ☐	Heart Problems ☐	Sleep Apnea ☐
AIDS/HIV ☐	Hepatitis Type_____ ☐	Frequent Headaches ☐
Anemia ☐	High Blood Pressure ☐	Dry Mouth ☐
Arthritis, Rheumatism ☐	Kidney Disease ☐	Jaw Pain ☐
Artificial Heart Valves ☐	Liver Disease ☐	Jaw Popping ☐
Artificial Joint ☐	Mitral Valve Prolapse ☐	Limited Opening ☐
Asthma ☐	Osteoporosis ☐	Clenching ☐
Blood Disease ☐	Pacemaker ☐	Grinding ☐
(Hemophilia, Sickle Cell)	Psychiatric Care ☐	Facial Pain/Numb ☐
Breathing problems ☐	Radiation Treatment ☐	Neck Ache ☐
Cancer ☐	Rheumatic Fever ☐	Bell's Palsy ☐
Chemotherapy ☐	Rheumatism ☐	Tobacco use ☐
Circulatory Problems ☐	Scarlet Fever ☐	Dental Anxiety ☐
Controlled	Sinus Trouble ☐	
Substance use ☐	Stroke ☐	ALLERGIES
Cough, frequent ☐	Swollen Feet/Ankles ☐	Aspirin ☐
Depression ☐	Swollen Neck Glands ☐	Codeine ☐
Diabetes ☐	Thyroid Problems ☐	Dental Anesthetics ☐
Epilepsy ☐	Tonsillitis ☐	Latex ☐
Fainting or Dizziness ☐	Tuberculosis ☐	Metals ☐
Glaucoma ☐	Tumor or Growths ☐	Penicillin ☐
Head/Neck injury ☐	Ulcer ☐	Sulfa ☐
Heart Murmur ☐	Venereal Diseases ☐	Not listed: _____

Are you currently taking prescription medications? If yes, please list below (name and purpose): _____

WOMEN: Are you pregnant? YES, NO (if yes, expected delivery date: _____)

Are you breastfeeding? YES, NO Are you taking birth control pills? YES, NO

Patient Signature: _____ Date: _____

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DENTAL HISTORY

Previous Dentist: _____ Phone: _____

Date of last dental visit: _____ Have you had a less than positive experience? YES NO

If Yes, please explain: _____

How do you assess your current dental health? (Please circle): Good Fair Poor

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? Electric toothbrush, Water-Pik, Soft-picks

Please check any that apply:

- Bad breath/taste in your mouth ☐
- Bleeding, swollen gums ☐
- Broken tooth or fillings ☐
- Clicking, popping in jaw ☐
- Grinding or clenching ☐
- Headache, ear aches, neck pain ☐
- Jaw joint pain ☐
- Loose, tipped, shifting teeth ☐
- Mouth ulcers or cold sores ☐
- Sensitivity (hot, cold, sweet) ☐
- Tooth pain or discomfort ☐

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health?
1 2 3 4 5 6 7 8 9 10

How would you rate your dental health?
1 2 3 4 5 6 7 8 9 10

Importance of my overall health?
1 2 3 4 5 6 7 8 9 10

Importance of preventive care to me?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your visit today? _____

What is the most important thing to you about your future smile and dental health?

_____

If you could change anything about the appearance of your smile, what would you want different?_____

_____

Have you been seen by an Orthodontist, had your bite adjusted, or treated for TMJ?

_____

If you could whiten your teeth for a cost anyone could afford, would you do it? _____

Patient Signature: _____ Date: _____

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OFFICE POLICY

NO SHOW AND CANCELLATION

In order to continue providing excellent quality, yet affordable dental services, it is important for our patients to understand that appointments are reserved for you in advance; please make effort to keep your appointments. You must notify us within 48 hours if you need to cancel your appointment. A $50 cancellation fee will be charged to accounts that appointments are cancelled less than 48 hours or are a no show.
A $250 deposit will be required to reserve an appointment for your surgery date. This fee will be applied to dental work that is scheduled to be done.

PATIENTS WITH DENTAL INSURANCE

It is your responsibility to provide our office with your dental plan and to let us know of any changes at your appointment. We will continue to try and help you understand your policy but please be aware that there are thousands of different policies and we do not know all of the limitations for all of the plans out there. If for any reason your insurance company does not pay for a procedure, the balance is your responsibility to pay in full upon receipt of the statement.

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCUR:

- The treatment goes over my yearly maximum.
- Any treatment that is denied by my insurance company.
- I am not eligible for insurance.
- I prevent or delay by not complying with requests for insurance forms or signatures.
- I do not complete my treatment and it results in non-payment by the insurance company.
- Lab and equipment costs that incurred due to a missed appointment.
- I received my insurance check and do not send it to the office.

By signing this, I have read and understand the above policy.

Patient Signature: _____ Date: _____

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CONSENT FOR TREATMENT

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough, diagnosis of (patient name) _____ 's dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and the employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff to use and disclosure of any oral written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and healthcare operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protections of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient Signature: _____ Date: _____

HIPPA RELEASE OF INFORMATION

I, _____, authorized the release of information including the diagnosis records; examination rendered to me and claims information. This information may be release to:

- ☐ Spouse_____
- ☐ Children_____
- ☐ Other_____
- ☐ Information is not to be released to anyone

Patient Signature: _____ Date: _____