



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

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 _____

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 Contact Name _____ Relation _____

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

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

PERSONAL INFORMATION

INSURANCE

EMERGENCY

DENTAL & MEDICAL INFORMATION

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

Please indicate any of the following problems:

- | | | |
|---|---|--|
| <input type="checkbox"/> Discomfort, clicking or popping in jaw | <input type="checkbox"/> Lost/broken filling(s) | <input type="checkbox"/> Stained teeth |
| <input type="checkbox"/> Red, swollen or bleeding gums | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Locking jar |
| <input type="checkbox"/> Sensitive tooth, teeth or gums | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Bed breath |
| <input type="checkbox"/> Blisters/sores in or around mouth | <input type="checkbox"/> Broken/chipped tooth | |

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)

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?

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

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 _____

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

Initials _____ Date _____ Comments _____

Initials _____ Date _____ Comments _____

Initials _____ Date _____ Comments _____

Initials _____ Date _____ Comments _____

Initials _____ Date _____ Comments _____

PAYMENT INFORMATION

AUTHORIZATION

OFFICE USE ONLY



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: _____