River City Dental Care

Patient Information

Patient's Name ______________________ Birthdate__________ S.S. No. ______________

Address ______________________ City______________ State ________ Zip__________

Phone #'s (H) ______________ (W) ______________ (C) ______________ E-mail______________

Employer______________________ Spouse/Guardian ______________________

Please answer all questions. Circle "YES" or "NO" or answer questions on lines provided.

Health History

- Date of last physical examination______________________
  Physician______________________
- Are you now under the care of a physician?........................YES NO
  If so, for what reason?______________________
- For women: Are you pregnant?..YES NO
- For women: Are you nursing?..YES NO
- Do you get short of breath easily? ....YES NO
- Do you faint easily? ....YES NO
- Do you get overly tired? ....YES NO
- Do your ankles swell?...YES NO
- Have you gained or lost weight recently?............................YES NO
- Have you ever had ulcers or stomach trouble? ....YES NO
- Do you bleed excessively from cuts or extractions?............YES NO
- Do you currently take blood thinners...................................YES NO
- Have you ever taken any prescribed
  appetite suppressant? ....YES NO
- Are you currently undergoing chemotherapy?.....................YES NO
- Are you currently or have you ever had radiation therapy? ......YES NO
- **Are you allergic to Penicillin, Codeine, Sulfa drugs, or anything else?** ....YES NO
  If yes to allergies, indicate to what:______________________
  ____
- **Do you have a medical condition for which premedication is required?** ....YES NO
- Are you presently taking medication
  (prescribed, over-the-counter or recreational)?...................YES NO
  If so, list all (including herbal supplements, aspirin, etc.):
  ____
- Have you ever had any surgeries or hospitalized?.............YES NO
  If yes, list: ______________________
  ____
- Have you ever been diagnosed with HIV/AIDS?..............YES NO
- Have you ever used any whitening products?.....................YES NO
- Have you, or do you use tobacco products? ....YES NO
- Have you now or have you ever been diagnosed or
  treated for osteoporosis or osteopenia?................................YES NO

Indicate which of the following you have *had* or *have* at present: Circle "YES" or "NO."

Asthma...YES NO	Kidney trouble ....YES NO	Rheumatic Fever..............................YES NO
Pneumonia..YES NO	Diabetes...YES NO	Mitral Valve Prolapse.......................YES NO
Tuberculosis ....YES NO	Tumors and growths........................YES NO	Joint replacement ....YES NO
Venereal disease ....YES NO	Seizure disorders.............................YES NO	Do you have any other medical conditions
Liver trouble....................................YES NO	Latex allergy ....YES NO	not listed?..YES NO
Hepatitis ....YES NO	Heart trouble ....YES NO	If so, list: ______________
Jaundice...YES NO	High blood pressure ....YES NO	______________
Blood transfusions ....YES NO	Heart murmur..................................YES NO	______________
Anemia...YES NO	Valve replacement...........................YES NO	

Dental History

- Date of last dental examination ______________________
  Were x-rays taken?..YES NO
- How often do you have dental examinations? ______________
- How often do you brush your teeth? ______________
- How often do you floss? ______________
- What other dental aids do you use (Interplak, toothpick, etc.)?
  ____
- Do your gums bleed when you
  brush or floss your teeth?...YES NO
- Does food tend to become caught in between your teeth?....YES NO
- Do you want to keep your teeth? ....YES NO
- Is there anything you'd change about your smile? ....YES NO
- Have you ever had:
  - Orthodontic treatment (braces) ?......................................YES NO
  - Periodontal treatment (gum therapy) ? ....YES NO
  - Endodontic treatment (root canal therapy) ?.....................YES NO
  - Oral surgery ?..YES NO
  - Serious injury to the mouth or head?...............................YES NO
- Have you experienced:
  - Difficulty opening or closing your mouth?.......................YES NO
  - Difficulty chewing on either side of your mouth? ....YES NO

This is to certify that I, the undersigned, believe the above health history to be true. I also consent to the performing of dental procedures agreed to be necessary or advisable including the possible use of diagnostic X-rays and local anesthesia. I authorize River City Dental Care assignment of any benefits from my insurance company. I understand that if my account is over 60 days a service charge of 1.5% per month will be applied to the unpaid balance. This is an annual rate of 18%. By providing us with your wireless/cell phone number, you are hereby granting us, and our agents or independent contractors, your consent to receive calls on your wireless/cell phone number for filing and debt collection purposes.

Patient's Signature (parent or guardian if patient is under 18)

X ______________________ Date / /

Dentist's Signature

X ______________________